CORE BUSINESS ORIENTATION

Blue Cross
Blue Shield
of Florida

An Independent Licensee of the
Blue Cross and Blue Shield Association.

Blue Cross
Blue Shield
of Florida

HUMAN RESOURCES DIVISION
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MEMO

To: Distribution List

From: Brad Biringer

Date: 6/5/96

Re: Material updates for the Core Business Orientation

Thank you for attending the pilot of the Core Business Orientation program. We value your participation and feedback.

Enclosed are some materials which we promised to send to you, including:

- Corrected pages in the Reengineering section for your participant's manual. (Please replace pages 89-92 with the corrected pages enclosed.)
- Contact information for additional information or questions. (Please place this page behind tab 12 in your manual.)
- A cover for the spine pocket of your participant's manual.

If you have any questions, please call me at x16353.

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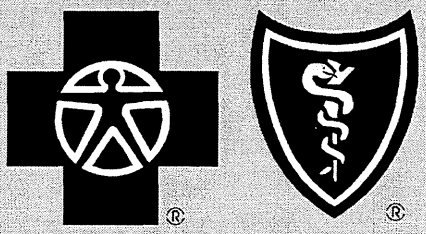
Core Business Orientation



Core Business Orientation

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Notes

Blue Cross and Blue Shield of Florida: The Company

Blue Cross and Blue Shield: The Company

The History of Blue Cross

The history of Blue Cross and Blue Shield is a story about Americans helping each other.

In 1929, Justin Ford Kimball, Ph.D, conceived the idea that would one day become "Blue Cross" at Baylor University Hospital, in Dallas, Texas. Dr. Kimball, the superintendent of the Dallas public schools, worked out an agreement with University Hospital by which each Dallas teacher would receive up to 21 days of hospital care free of charge for the annual sum of $6 per teacher. The concept of pre-paid health care was born.

By 1932, community-wide pre-payment plans offering customers a choice of hospitals began to emerge. By 1939, more than three million Americans were involved.

In 1932, E. A. van Steenwyk, first executive of the Hospital Service Association of St. Paul, Minnesota, started using a blue cross on company stationery to identify his program.

Other programs adopted the blue cross and in 1939, it became the official emblem for the American Hospital Association (AHA). As originally designed, the symbol was in the shape of the Geneva Cross – the international emblem for the relief of the sick and wounded. Superimposed on the cross was a seal of the AHA.

In 1972, when the Blue Cross Association became independent of the AHA, the symbol was changed by placing a human figure within the cross to better symbolize BCA's primary focus on serving the people.

The blue cross still symbolizes hospital care.

The History of Blue Shield

Around the turn of the century, lumbering and mining were popular professions in the Pacific Northwest. County medical societies, for only pennies each month, agreed to provide medical treatments for the injury-prone men whose employers contributed to the pool. Soon, plans were formed to collect the premiums, administer the claims and disburse the payments.

Twenty years passed before the American Medical Association (AMA) endorsed the principle of voluntary health insurance, encouraging physicians' cooperation. By 1939 the first official Blue Shield plan, then known as the California Physicians Service, was in operation. The shield was adopted as the physicians services symbol because throughout history, the shield has served to protect the body.

Superimposed upon it is the knotty staff with the entwined serpents (known as the caduceus), the symbol of the Greek god of medicine. This symbol continues today as the symbol of the physician and ancillary (supporting) care.

The Blue Shield name and symbol were first used by a pre-paid plan in Buffalo, New York, known today as Blue Shield of Western New York. The name and symbol were informally adopted by the Associated Medical Care Plans in 1948, and registered officially in 1951 for Blue Shield Plans.

The Blue Cross and Blue Shield Association

In 1982, the Blue Cross and the Blue Shield plans formally merged to form a nationwide alliance of 67 independent, self-ruling corporations, called ***plans***. Today, the Blue Cross and Blue Shield plans provide services to approximately 100 million Americans (more than 1/3 of the United States population), through both direct coverage to their members and through contracts with the United States Government's Health Care Financing Administration (HCFA) which governs federal Medicare programs.

The coordinating agency for the plans is the ***Blue Cross Blue Shield Association*** (BCBSA), located in Chicago.

The Association plays several important roles for Blue Cross and Blue Shield plans:

- it serves as a spokesperson for the plans in matters of national concern
- it begins and organizes public education programs
- it contributes to cost containment efforts
- it provides telecommunications, research, statistical, actuarial, marketing and other services.

Blue Cross Blue Shield of Florida's affiliation with the Blue Cross Blue Shield Association has helped position BCBSF as the most widely recognized insurance company in Florida. Through the association, BCBSF participates in a nationwide network which allows it to communicate with other plans to better service BCBSF's national accounts.

A Mutual Insurance Company

The separate companies that make up the "Blues" plans operate as not-for-profit, mutual insurance, or stock-owned companies as they are allowed under their state regulations. Until recently, all Blues plans operated as ***not-for-profit*** companies (as opposed to commercial insurance companies) and as such were exempt by law from various state taxes.

BCBSF is a not-for-profit organization that became licensed as a ***mutual insurance company*** in 1982. Mutual insurance companies are owned by the policyholders. The mutual benefit attitude of such companies means that profits earned may be returned to policyholders in the form of dividends. Not all profits are distributed as dividends, however; some are used for research and development of new products, future investment or loss coverage. ***Reserve funds*** are monies set aside to cover future claims and operating expenses.

As a mutual insurance company, BCBSF is subject to the same taxes and regulatory rate filing guidelines as for-profit companies. In 1993, for example, BCBSF paid approximately $57 million in federal and state taxes and assessments. The regulatory rate filing guidelines allow BCBSF to implement rate changes 30 days after the rate filing is submitted to the Florida Department of Insurance (DOI), which has the authority to regulate rate increases. Without the mutual insurance company status, the company would be required to wait for DOI approval before using the new rates, as required of companies with non-profit status.

The Role of Government in Insurance

The insurance business is subject to a greater degree of government regulation than many other businesses. This is because an insurer must have the means of fulfilling its promise of future performance for the customer (in exchange for the customer's premium payment). The government helps to protect the policyholder by ensuring the insurer is solvent—having sufficient financial reserves to handle any payment it may be called upon to make. The government also ensures that insurance contracts, which are drawn up by the insurer, do not contain unreasonable restrictions and limitations which would make them of little value to the person seeking protection.

Most insurance regulation is primarily under the control of state government. Each state has its own Insurance Department, headed by an Insurance Commissioner. The National Association of Insurance Commissioners (NAIC) helps to promote some degree of uniformity in insurance regulation among various states.

Blue Cross Blue Shield

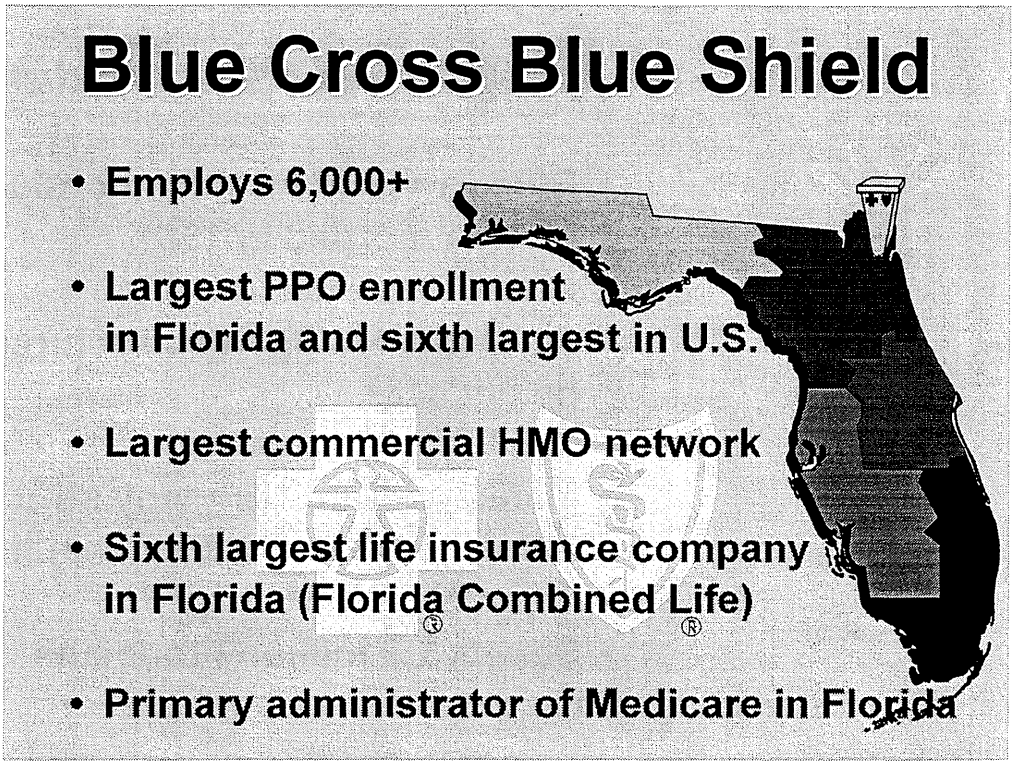
- Blue Cross of Florida and Blue Shield of Florida merged in 1981
- Insurance company structured to *finance* health care
- Managed Care company structured to manage the *delivery* of health care
- Serves 1.9 million® Floridians®

BCBSF Today

Blue Cross Blue Shield of Florida (BCBSF) grew out of a merging of two organizations — the Florida Hospital Service Corporation and the Florida Medical Services Corporation. Both companies began in the 1940s and later became Blue Cross of Florida and Blue Shield of Florida, respectively. The two merged in 1981 in a strategic move that resulted in greater financial flexibility and a better competitive position in the marketplace.

The business began as a health insurance company structured to ***finance*** health care using simple financing mechanisms, such as prepayment, to give as many people as possible access to health care. In just a little more than a decade, however, the company has become a highly successful managed care company. We have introduced new products that help manage the ***delivery*** of health care — that is, manage the cost of services and how those services are delivered.

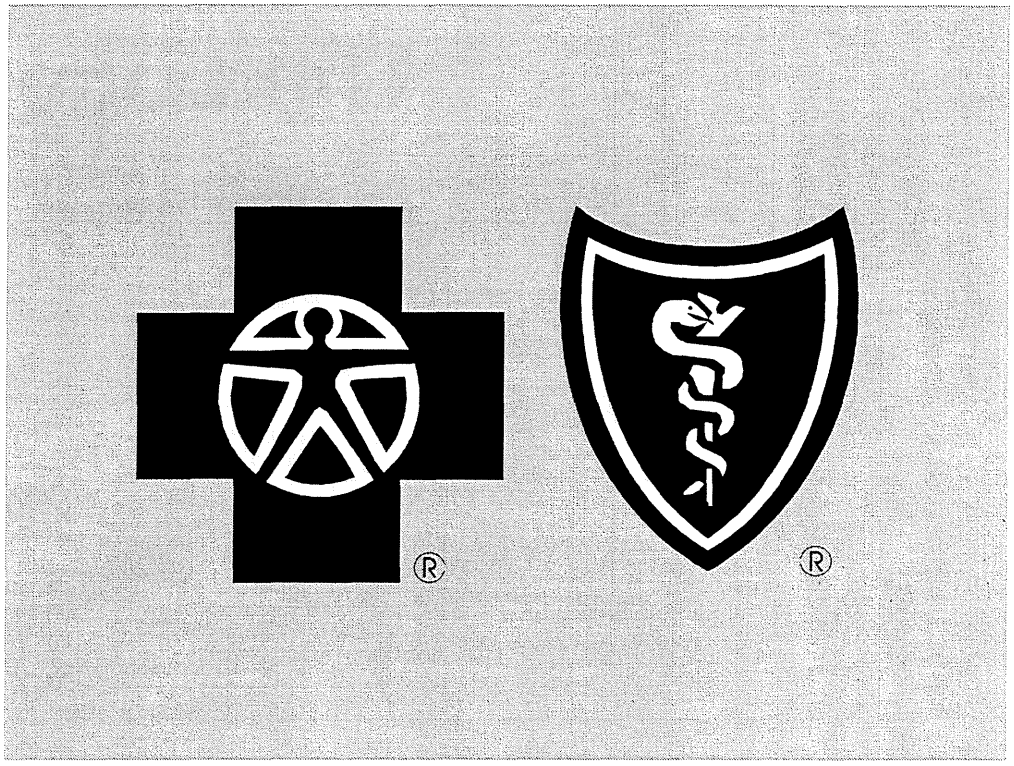
Today BCBSF is the state's largest provider of health insurance and managed care products and services, serving approximately 1.9 million Floridians.



BCBSF Today *(continued)*

Facts about Blue Cross Blue Shield of Florida:

- employs 6,000-plus people, located in Jacksonville and regional offices across the state and has its own board of directors
- has the largest ***preferred provider organization*** (PPO) enrollment in Florida and the sixth largest in the U.S.
- has the largest commercial ***health maintenance organization*** (HMO) network in Florida
- Florida Combined Life is the state's sixth largest life insurance company
- the primary administrator of both Medicare programs in the state of Florida



Discussion

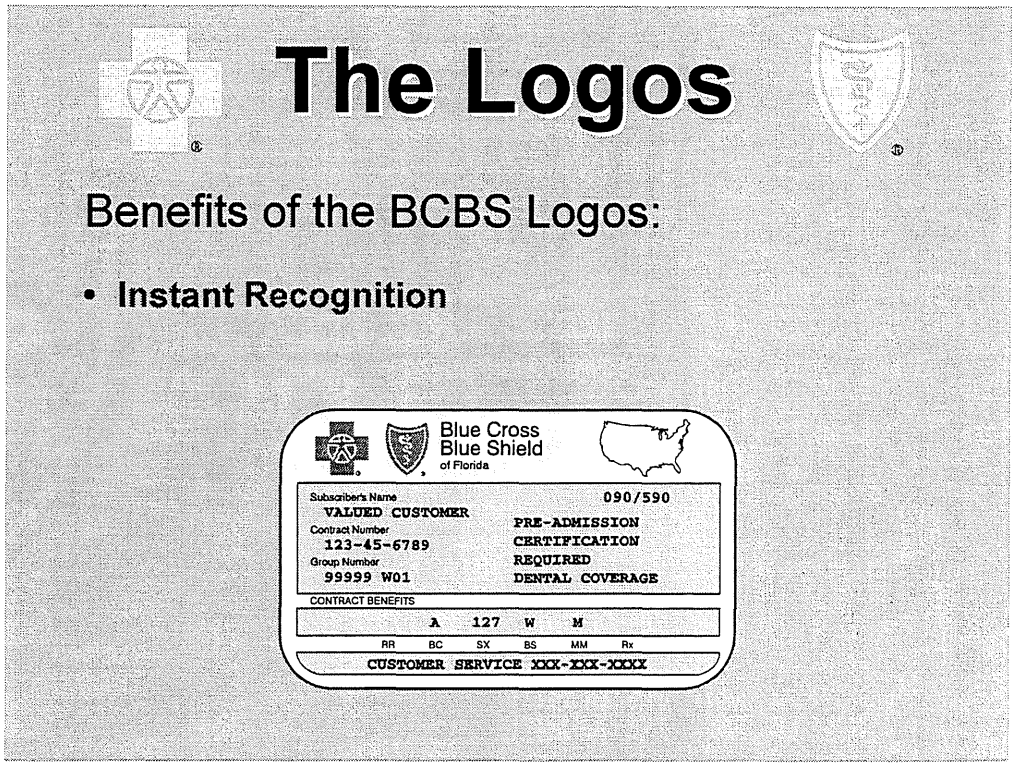
When you see the BCBS Logo what comes to mind? From the perspectives of:

Employees

Customers

Providers

Competitors

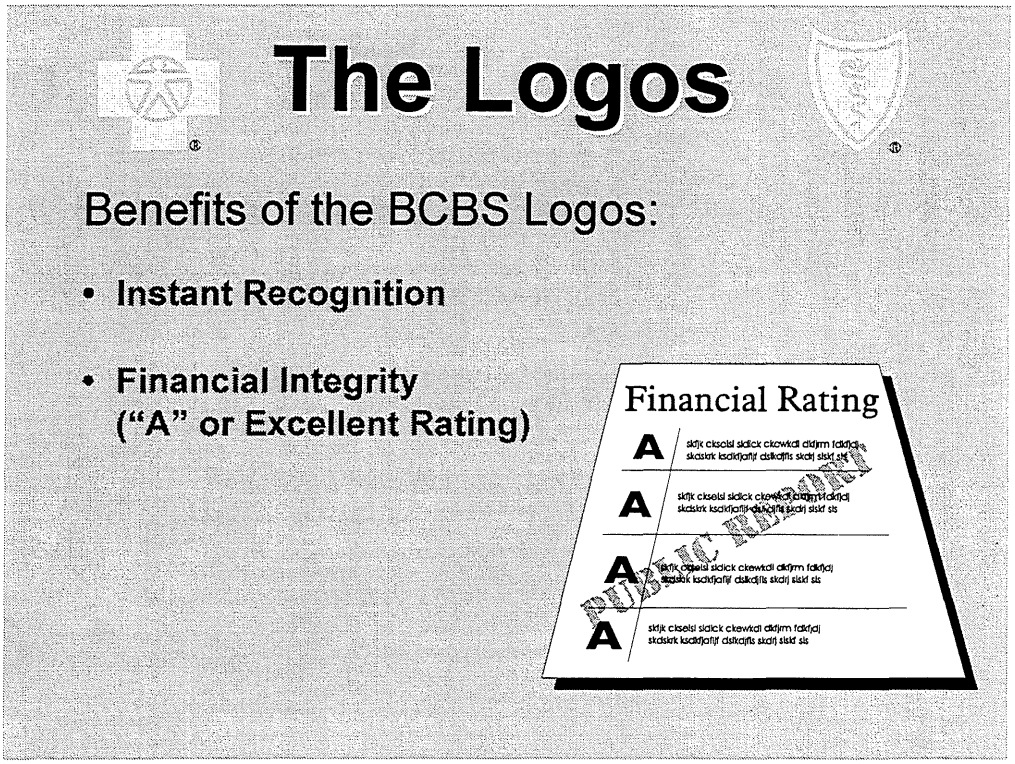


Benefits of the BCBS Logos

The value of Blue Cross and Blue Shield's trademark has been developed over the years. Many advantages go along with the use of the Blue Cross and the Blue Shield logos, which differentiates the Blues from other health care companies.

As a federation of independent plans, Blue Cross and Blue Shield companies serve all 50 states and provide health care coverage for roughly 25% of the nation's population, making the Blue Plans the largest payor in the nation, with assets of more than $38 billion in 1994. For this reason, a BCBS insurance card provides **instant recognition** in a hospital or doctor's office.

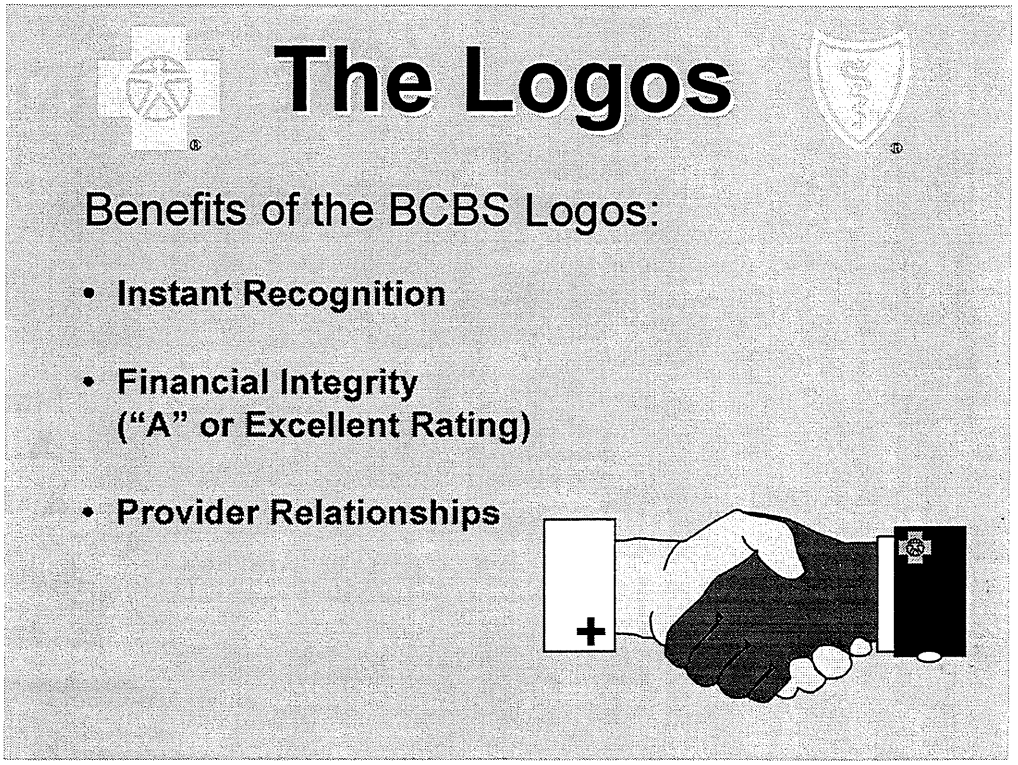
Health care providers and the policyholders can be sure that incurred costs for services will be paid efficiently and accurately.



Benefits of BCBS Logos *(continued)*

In July 1994, BCBSF received an "A" or "Excellent" rating from A.M. Best, an independent company that evaluates an insurer's financial strength, operating performance and ability to meet policyholder obligations. Nineteen-ninety four also marked the third consecutive year that the independent insurance rating firm of Standard & Poor's gave BCBSF an "A+" rating. These ratings reflect BCBSF's dominant position in the health care market, its consistently strong earnings performance and its strong position in managed care.

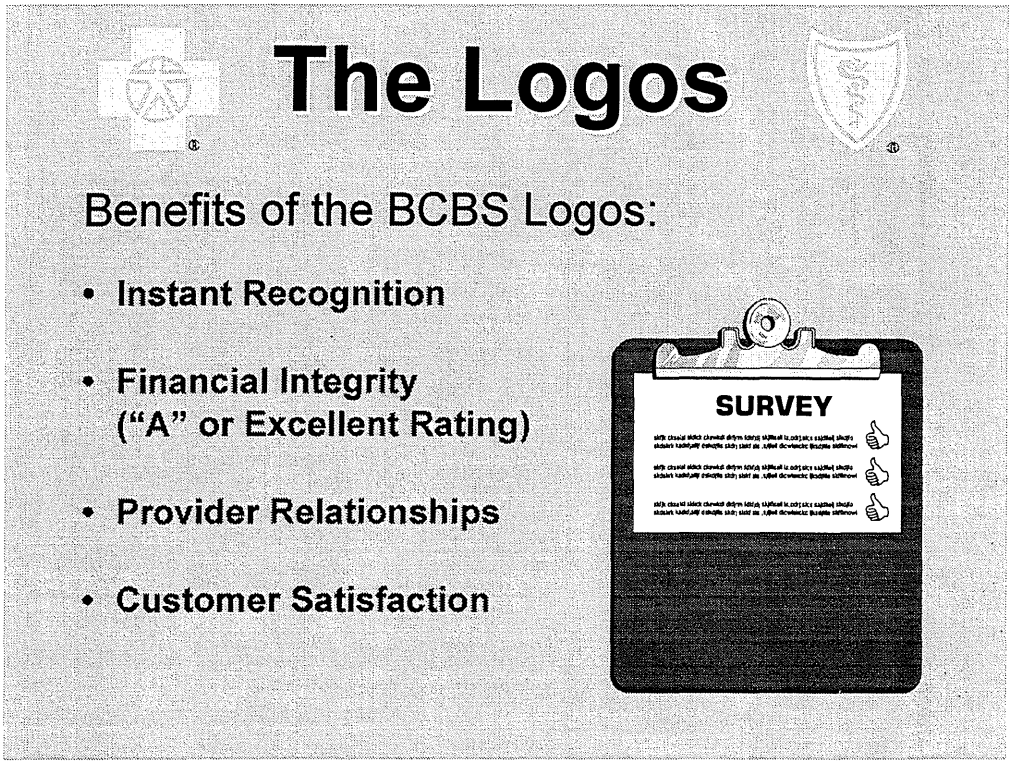
Florida Combined Life (FCL) Insurance Company, Inc., a for-profit wholly owned subsidiary of BCBSF, was also rated "A" (excellent) by A.M. Best in 1994.



Benefits of BCBS Logos *(continued)*

Over the years, Blue Cross Blue Shield of Florida has earned a reputation with health care providers as a "user friendly" company that offers high quality service.

Reasons for this reputation include BCBSF's efforts to:
- simplify and expedite payment methods for services rendered
- continually place emphasis on conducting educational sessions with providers
- listen and respond to provider's needs



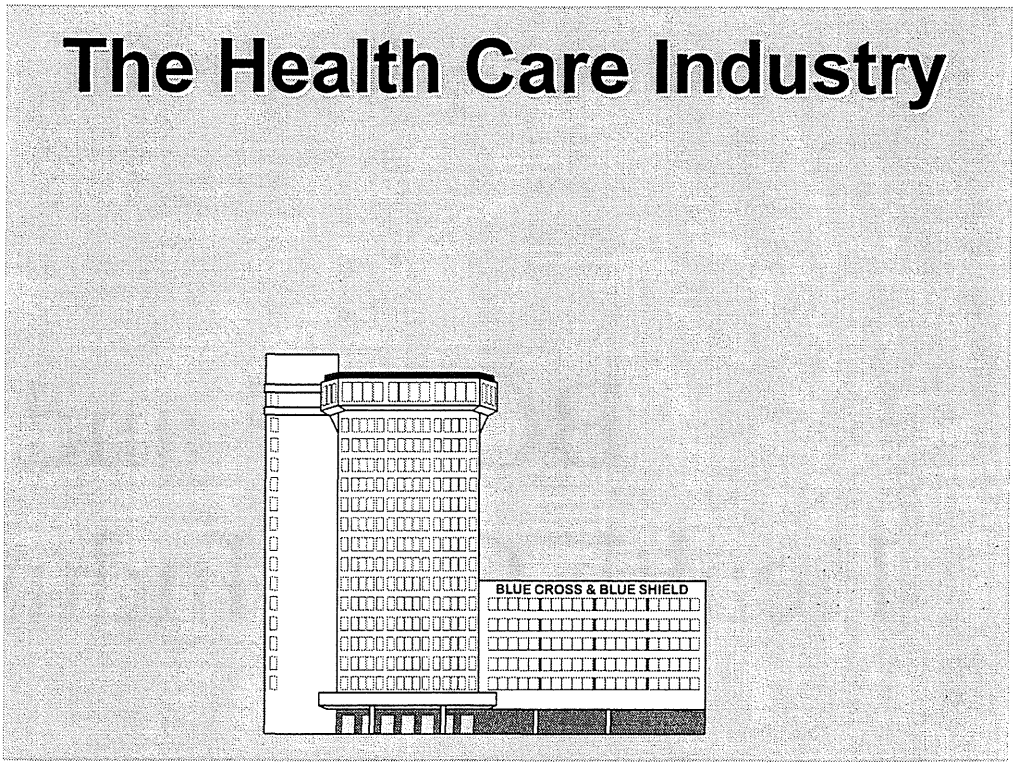
Benefits of BCBS Logos *(continued)*

BCBSF regularly conducts satisfaction surveys to determine the ***members'*** satisfaction levels with their medical care and the convenience of services offered by the company. Recent survey results show that more than 90 percent of BCBSF subscribers are either "satisfied" or "very satisfied" with the quality of care provided by physicians in BCBSF's managed care networks.

Notes

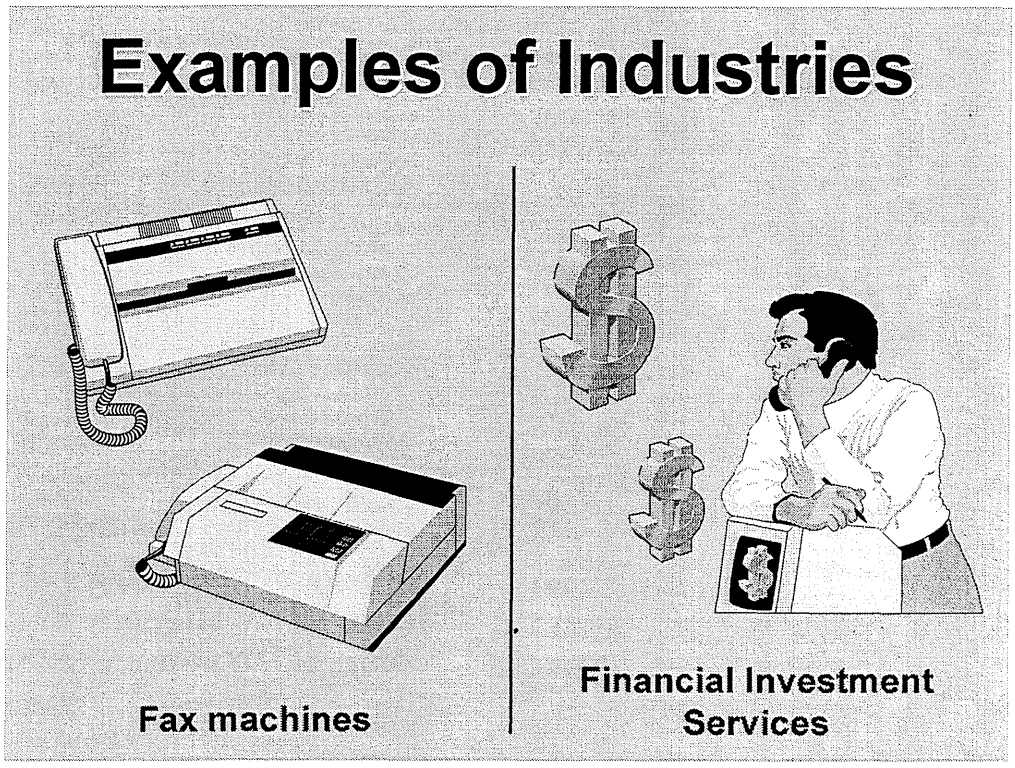
BCBSF and the Health Care Industry

The Health Care Industry



The Health Care Industry

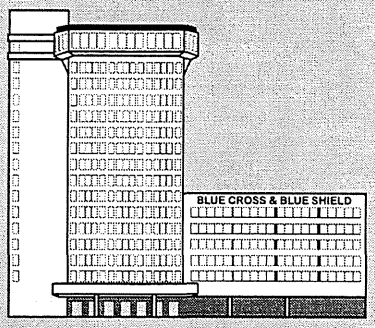
Today's rapidly changing health care environment imposes unprecedented challenges for Blue Cross Blue Shield of Florida. Because BCBSF has responded so successfully to new market demands in recent years, it remains a leader in the industry. Now, with a focus on the future, BCBSF is not only responding to today's environment, but employing innovative and competitive strategies that will influence the health care delivery marketplace.



What is an Industry?

An ***industry*** is a group of firms that produce products or services that are close substitutes for each other. Companies that produce fax machines, for example, form an industry. Bankers, brokerages, money management companies and other firms that offer financial investment services comprise another industry. Because companies within the same industry produce similar products or offer like services, they compete directly with each other for the same customers.

Five Competitive Forces



". . . Five competitive forces jointly determine the intensity of industry competition and profitability."

-- Michael Porter

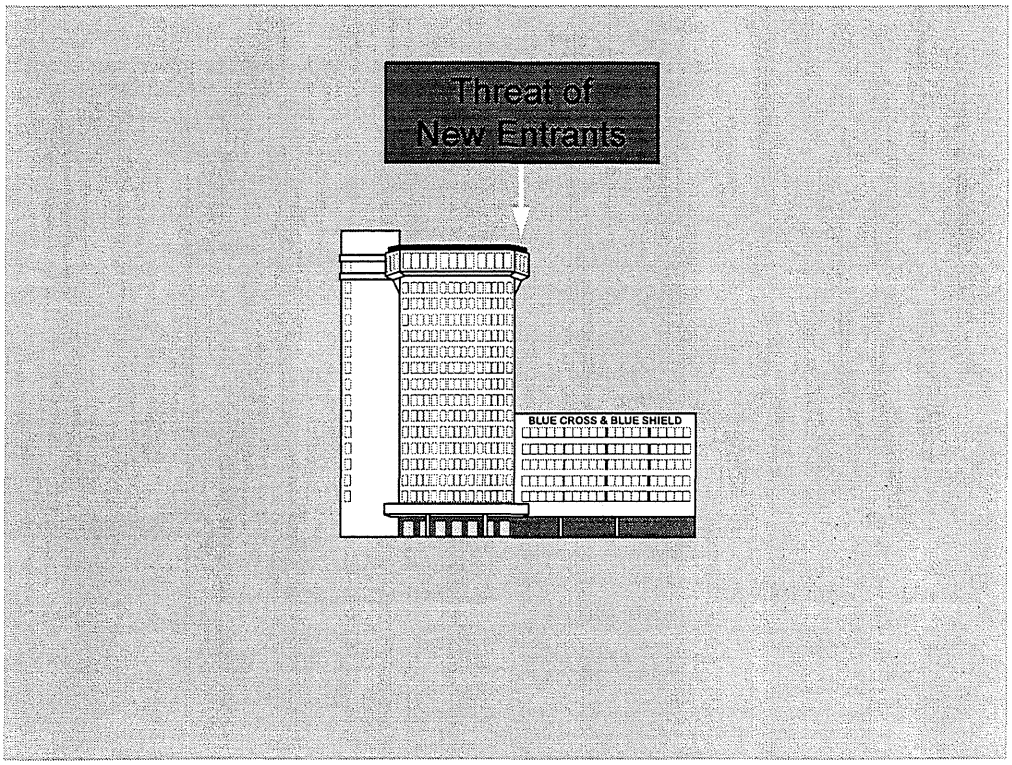
Harvard Business School

Five Forces of Competition

How can a company create and maintain a competitive advantage over other companies in the same industry? Harvard Business School industry expert Michael Porter says there are **five** forces of competition that companies must be aware of in order to successfully compete in the marketplace. The goal for any business is to either guard itself against these forces or to influence them in its favor.

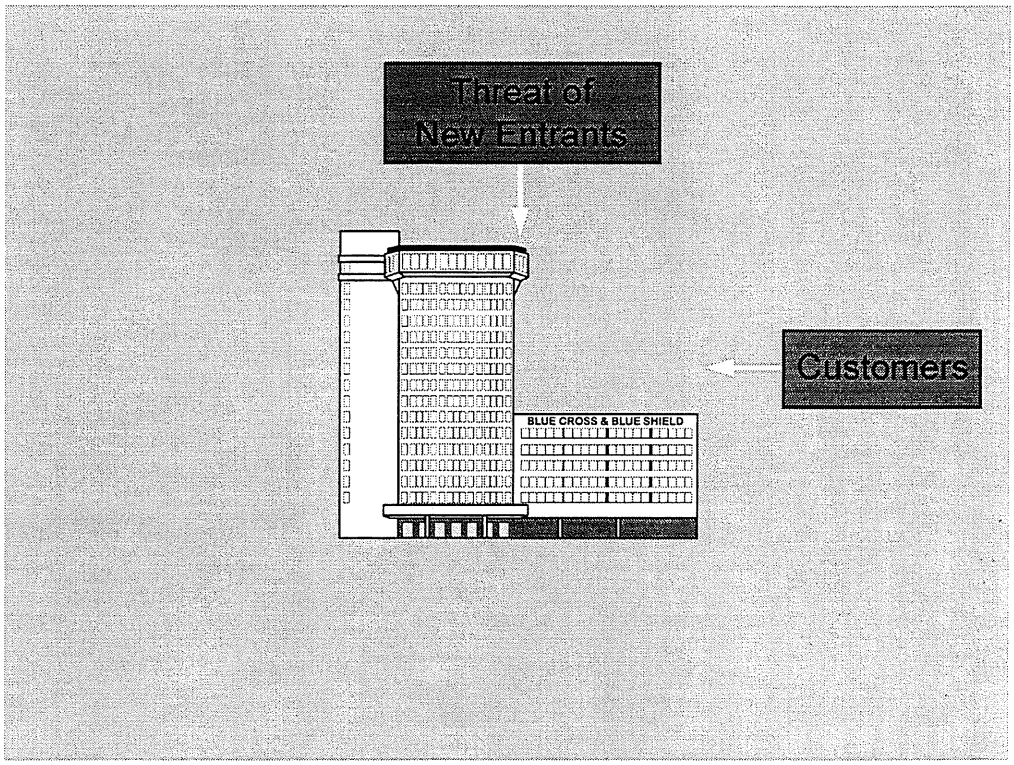
These five forces are:

- threat of new entrants
- customers
- substitute products
- suppliers
- competitors



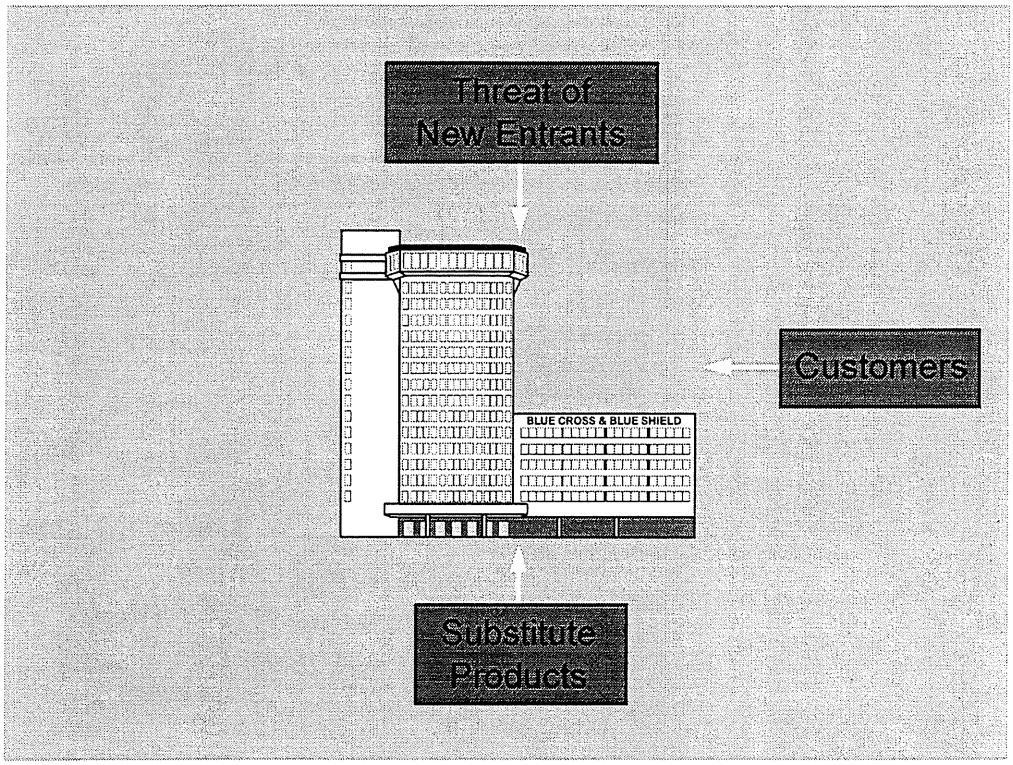
Five Forces of Competition *(continued)*

Businesses in an industry must be aware of new entrants into the marketplace. New companies can bring new services, products, or technologies that better meet the needs of the customer at a lower price and capture a share of the market.



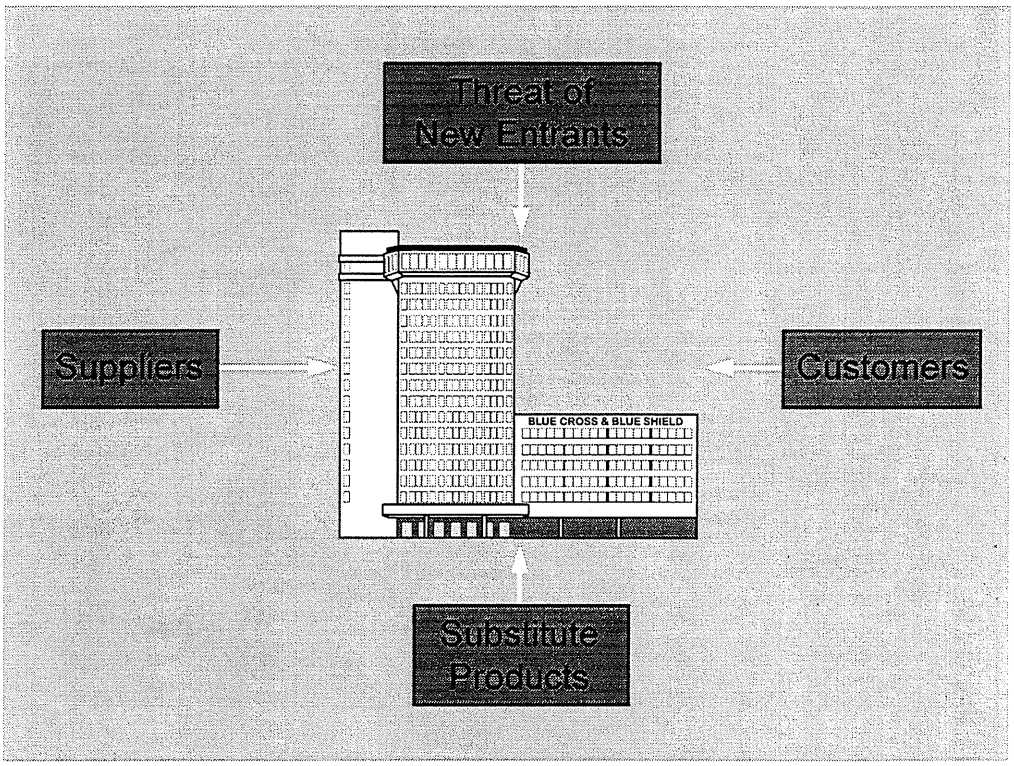
Five Forces of Competition *(continued)*

Customers have needs and expectations. Whether a company can provide the services or products that meet those needs affects competition in the industry. Other factors, such as the number of buyers in an area or how much bargaining power a group of customers has also creates competitive forces.



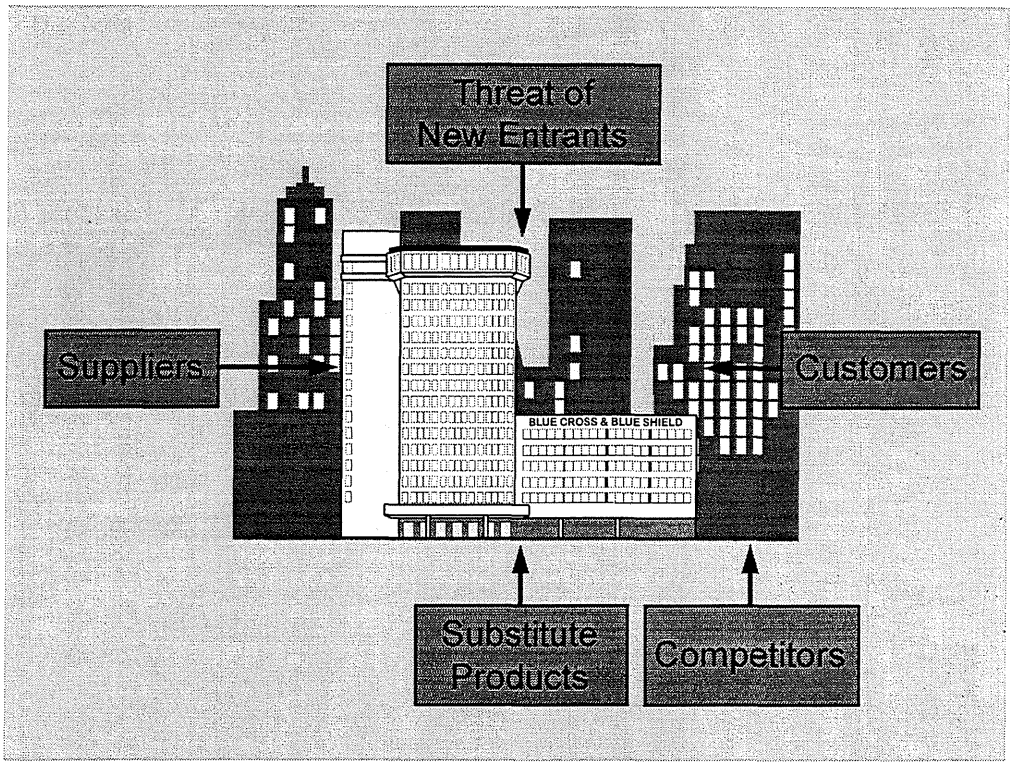
Five Forces of Competition *(continued)*

The presence of similar products in the marketplace gives customers the option of "shopping around." With an array of products to choose from, the customer can select the one which best meets his/her needs for the lowest price. Consequently, the introduction of close substitute products limits the price a business can charge for its products.



Five Forces of Competition *(continued)*

Suppliers supply or provide the "raw materials" a company uses in its products. The cost (price and use) of these materials can affect how much profit a company is able to make. It is important, then, for a company to do business with suppliers who supply the best product at a reasonable cost.



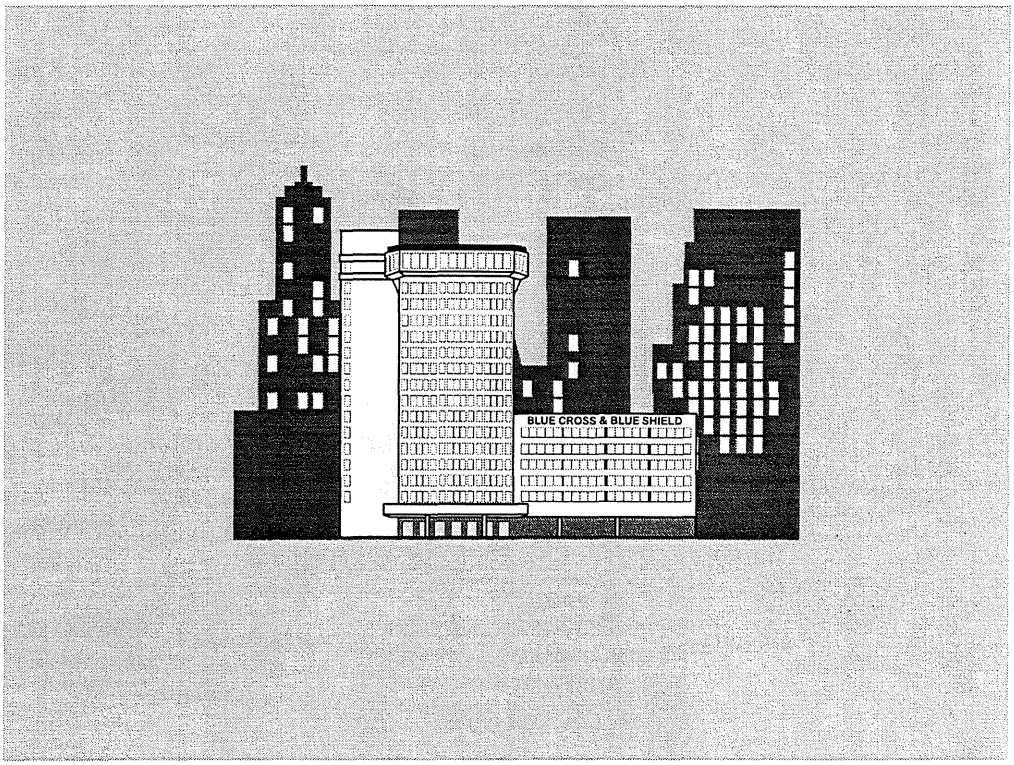
Five Forces of Competition *(continued)*

Fierce competitive rivalry between companies in an industry can consume a company's profits.

Today, the intensity of competitive forces in the health insurance/managed care industry in America is escalating. One industry observer has described the competitive conditions in the health care industry as "permanent white water."

The impact of competition is felt everywhere:

- Customers are demanding high quality care at more affordable prices.
- New competitors are entering the health care playing field and forming alliances in an effort to better meet customer needs at a lower cost.
- Dramatic innovations in drugs and technology are creating entirely new or substitute products which are revolutionizing the delivery of health care.
- Legislative reform has introduced new avenues by which consumers can purchase health insurance coverage.



Discussion

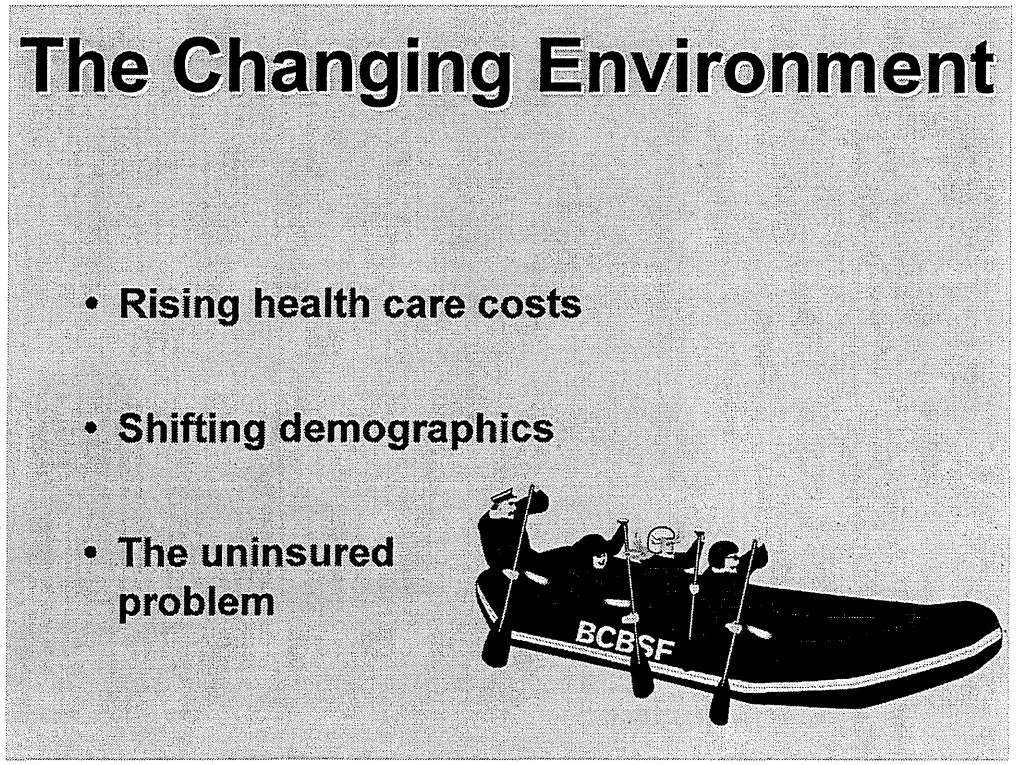
NEW ENTRANTS:
Who are they?

CUSTOMERS:
What do we know about our customers?

SUPPLIERS:
What are some special considerations for us?

SUBSTITUTE PRODUCTS:
How are they affecting our business?

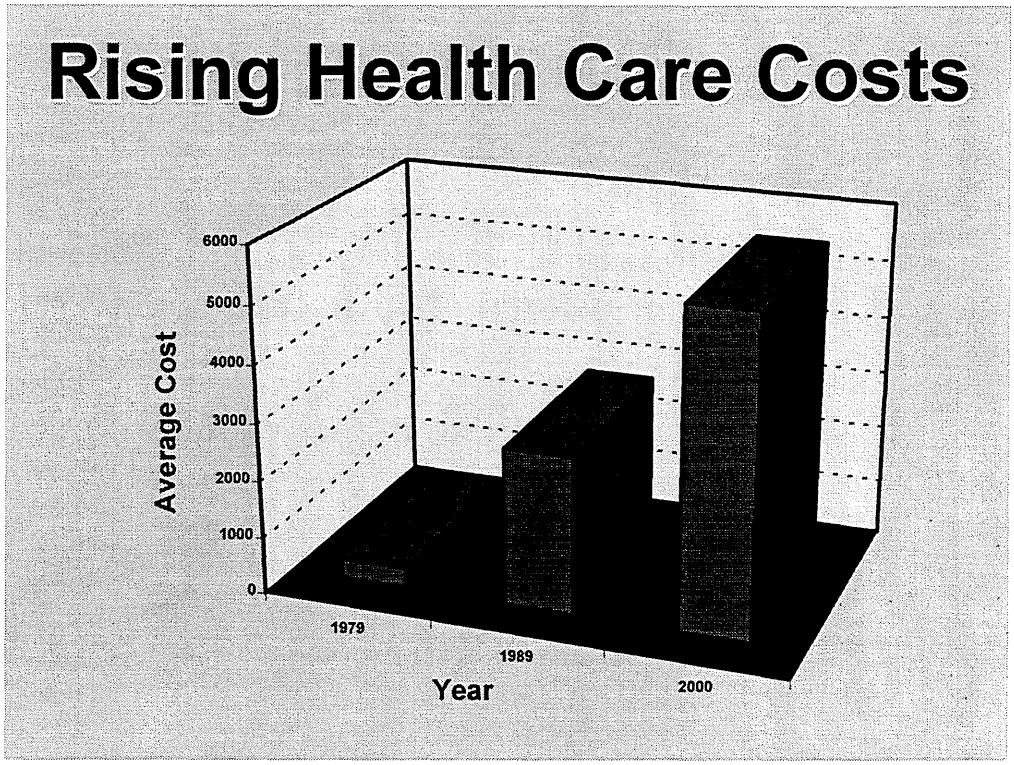
COMPETITION:
What are some recent developments?



The Changing Environment

Health care is in a state of flux. The ways in which health care services are delivered and financed are experiencing significant changes. Understanding these changes requires insight into demographic, economic, regulatory and social factors that are contributing to this changing environment.

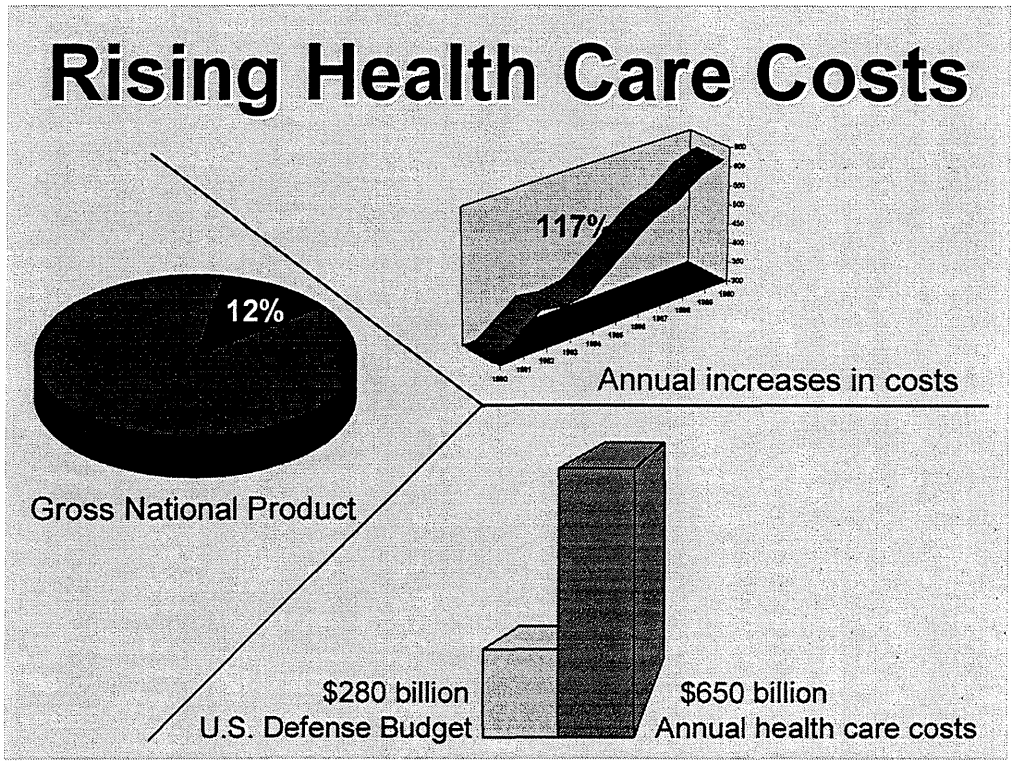
Three of the elements influencing health care industry changes are:
- Rising health care costs
- Shifting demographics
- The uninsured



The Changing Environment *(continued)*

Today, health care costs are rising all the time—at more than twice the pace of general inflation.

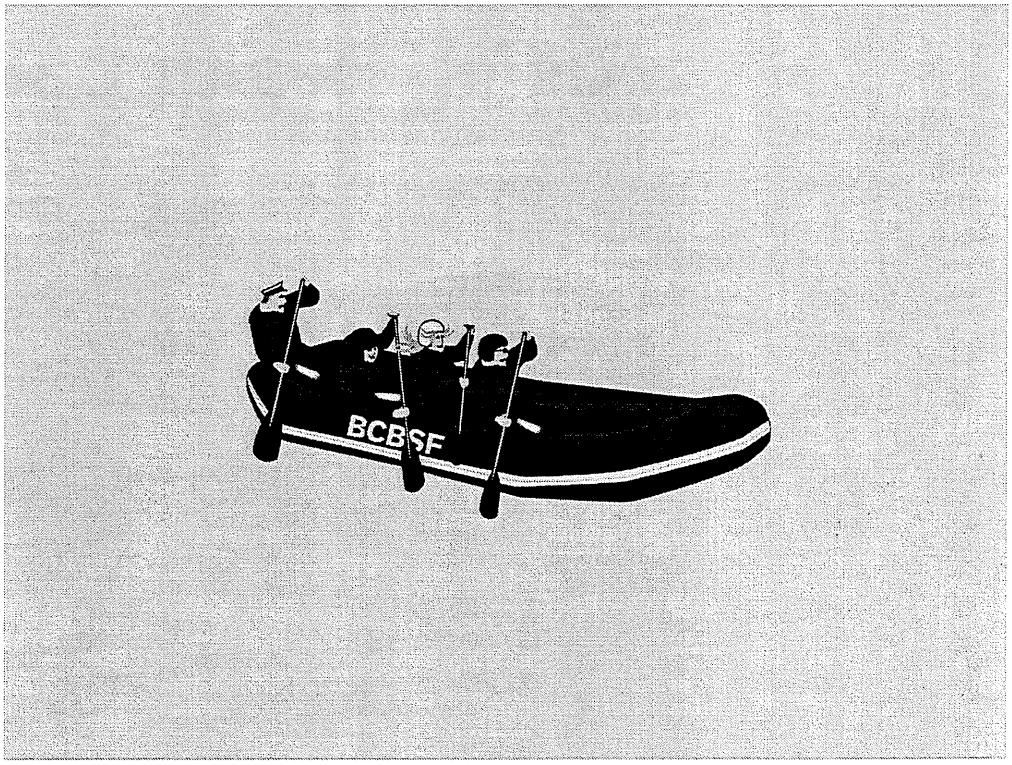
This graph shows how health care costs have risen since 1979. In 1979, the cost of health care per person was $349. By 1989, that cost reached $2,748 per person. It is estimated that health care costs will reach an estimated $5,500 per person by the year 2000.



The Changing Environment *(continued)*

The Consumer Price Index reports that, between 1980 and 1990, the cost of medical care increased 117 percent, reaching more than $650 billion. This amount is more than twice the figure ($296 billion) budgeted and spent by the U.S. Defense Department in 1990.

In 1995, health care costs comprise 12.2 percent of our country's Gross National Product (GNP) – that is, health care spending levels represent about 12 percent of our nation's goods and services. This is an 800 percent increase since the 1960s, and this figure is expected to reach 17 percent of the GNP by the year 2000!

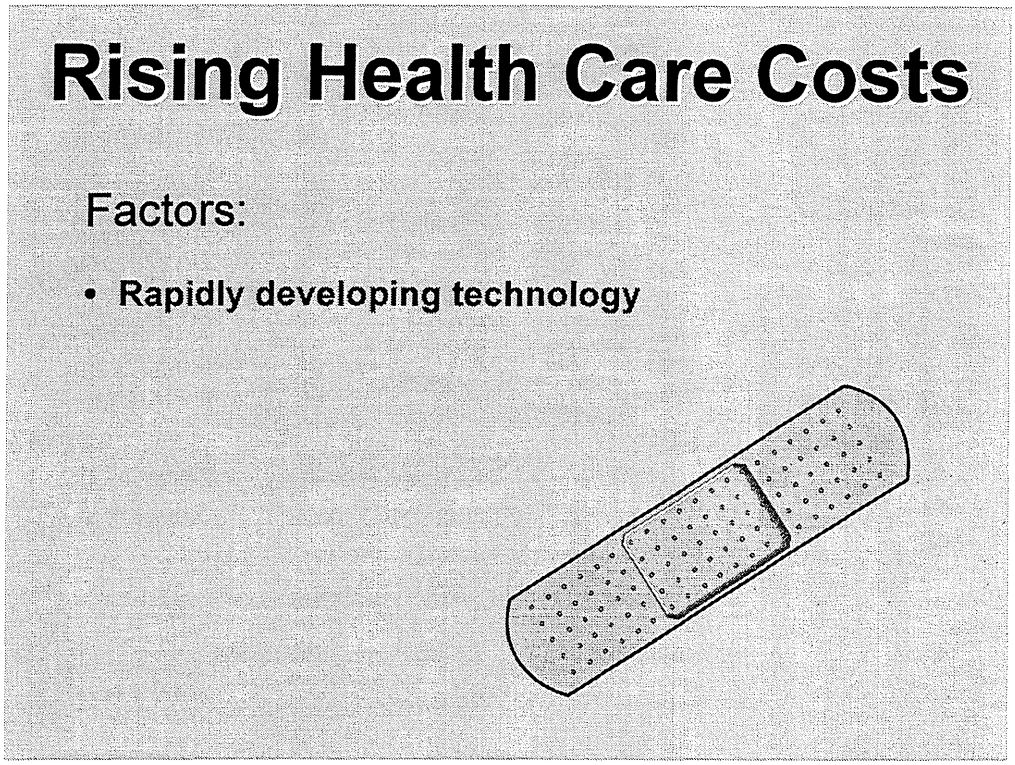


Discussion

What are some causes of rising costs?

How are demographics changing today?

What are some reasons people are uninsured?

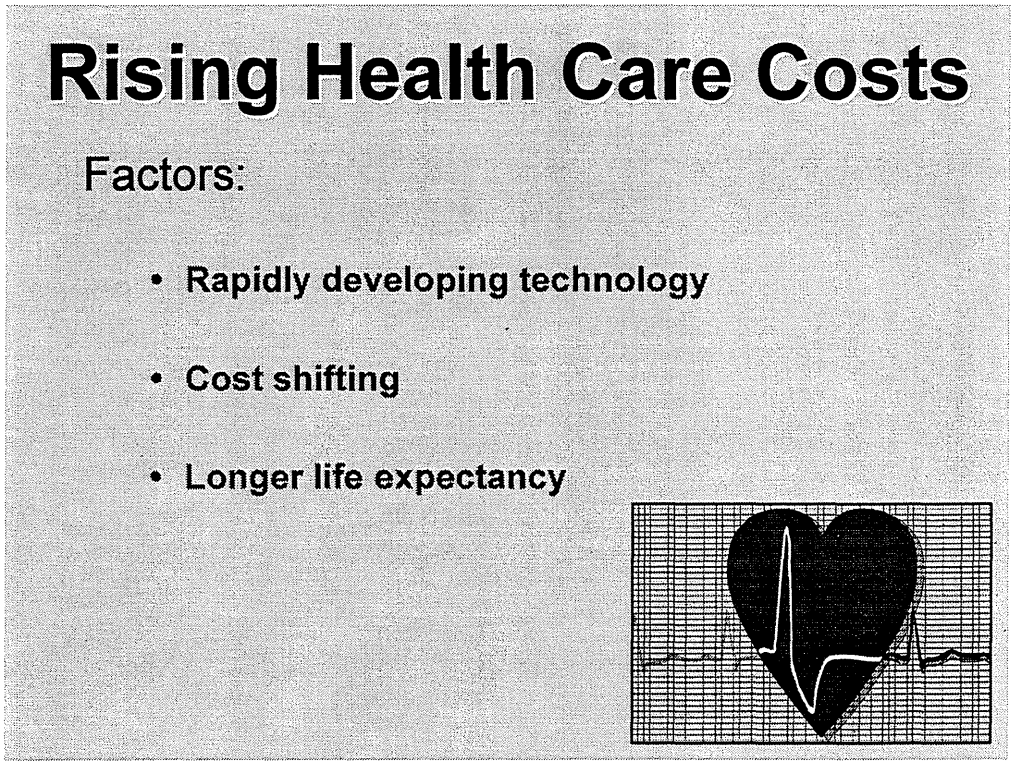


The Changing Environment *(continued)*

Blue Cross Blue Shield of Florida's rapidly growing, innovative coordinated care programs like HMOs and PPOs are lowering the costs of quality health care.

However, critics warn that, soon, only the wealthy will be able to afford medical care as we know it today. How has the cost of health care reached these proportions? Several factors have affected this trend.

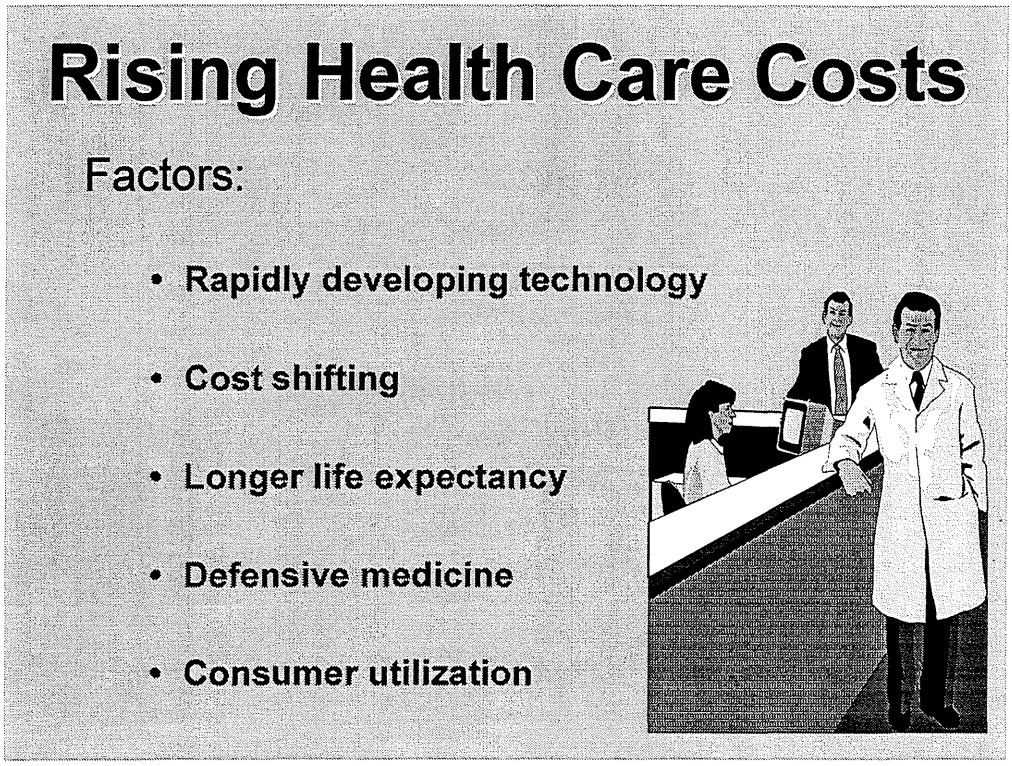
- ***Rapidly developing technology*** is a positive component of health care in the United States, but it is expensive. The type of critical care (including drugs, specialized processes, and modern equipment) used for a low-birth-weight infant, for example, can run as much as $400,000 during the initial months of life. If a high technology medicine or procedure is perceived as "life-saving," doctors want to use it, and patients, often having little knowledge of the true cost of such technological procedures, expect unimpeded access to the medical solution.



The Changing Environment *(continued)*

- ***Cost shifting*** by providers — that is, increasing charges for patients who *can* pay to help pay for patients who cannot or do not pay — accounts for a large percentage of the rising costs. For example, because the federal government has limited what hospitals and doctors can charge for treatments for Medicare patients, some providers charge the private sector more to make up the difference.

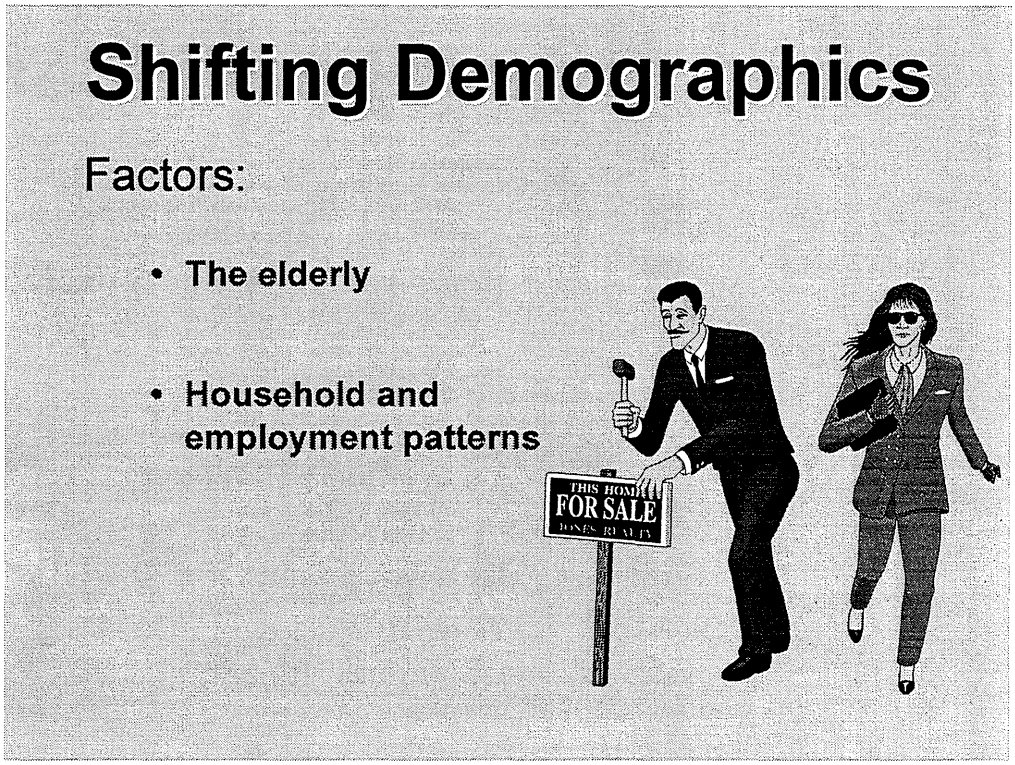
- ***Longer life expectancy*** among seniors also plays a role in rising costs. The elderly represent only 12.7 percent of the population, but a whopping 33 percent of all health care expenses. The census bureau estimates that by the year 2020 the elderly will constitute 18 percent of the population, and as this figure rises, so will their health care expenses.



The Changing Environment *(continued)*

- ***Defensive medicine*** is costly. Due to wide variations in physician's practice patterns across the country and the lack of scientific information regarding the efficacy of some procedures, some prescribed services may be medically unnecessary for the patient. Hospitals and doctors increasingly must practice defensive medicine to avoid malpractice litigation. It has been estimated that 25-33 percent of all health care services are not medically necessary. This translates into $150 billion in costs.

- ***Consumer Utilization.*** Americans tend to go to the doctor too often. According to a recent study, Amercians spend 31 percent more of their resources on health care than do Canadians, 65 percent more than the Japanese and 79 percent more than the English. When it comes to health care, Americans want nothing but the best and price seems secondary.

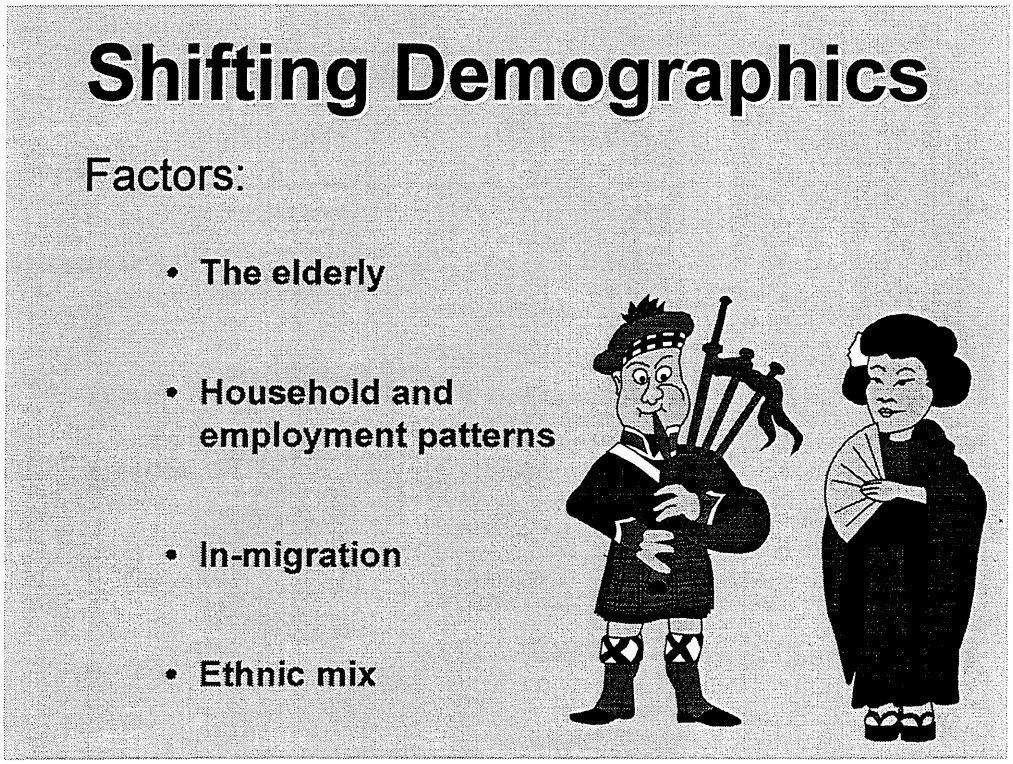


The Changing Environment *(continued)*

Variations in the statistical characteristics of human populations or ***shifting demographics***, are placing new demands on America's and Florida's health care systems. Some dynamics precipitating change in the health care environment include:

- ***The Elderly***. The census bureau estimates that by the year 2020, the elderly will constitute 18 percent of the population. By 2030, 22 percent of the nation's population will be in the "elderly" category. As a larger portion of the population reaches the over-50 mark, they will want a wide range of services to respond to their health care needs, such as long-term health care, home health care, adult day care and hospice care.

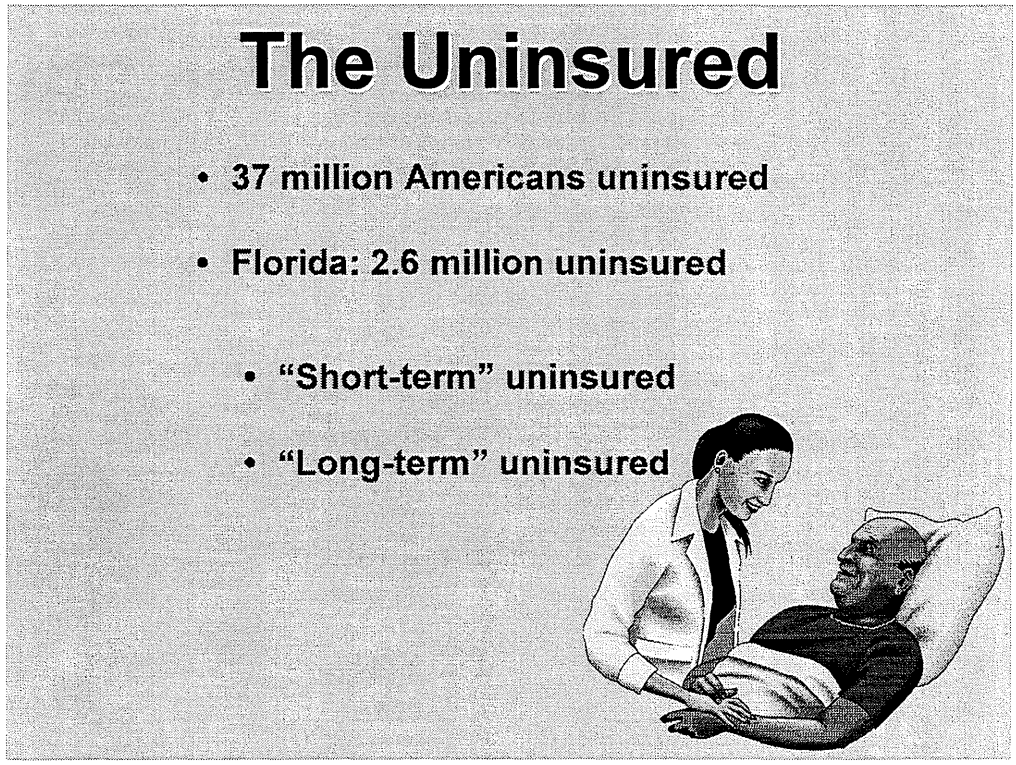
- ***Household and Employment Patterns***. In the past two decades, the number of single-person households, childless couples, single-parent families and two-worker families have increased. This has led to demands for insurance benefits that meet the specific needs of these groups.



The Changing Environment *(continued)*

- ***In-migration*** brings a unique health care situation to Florida. In the last two decades, Florida's population has grown more by people moving into the state than by people being born here. During the winter months, populations in certain regions of Florida almost double due to an influx of seasonal visitors. These influxes place increasing demands health care delivery. The lack of an established relationship with a primary care physician to ensure continuity of care and access of health care information can pose problems that must be addressed.

- ***Ethnic mix*** may dictate changes in terms of how health care is delivered in the future in many states. By the year 2000, 53 percent of Florida's population may be composed of ethnic populations who are more used to going to a clinic rather than a private physician for care. Ethnic mix demands an understanding of cultural and societal differences and needs. Unique approaches are required to designing the products we deliver, including physician and provider selection, and specific utilization management and quality programs.

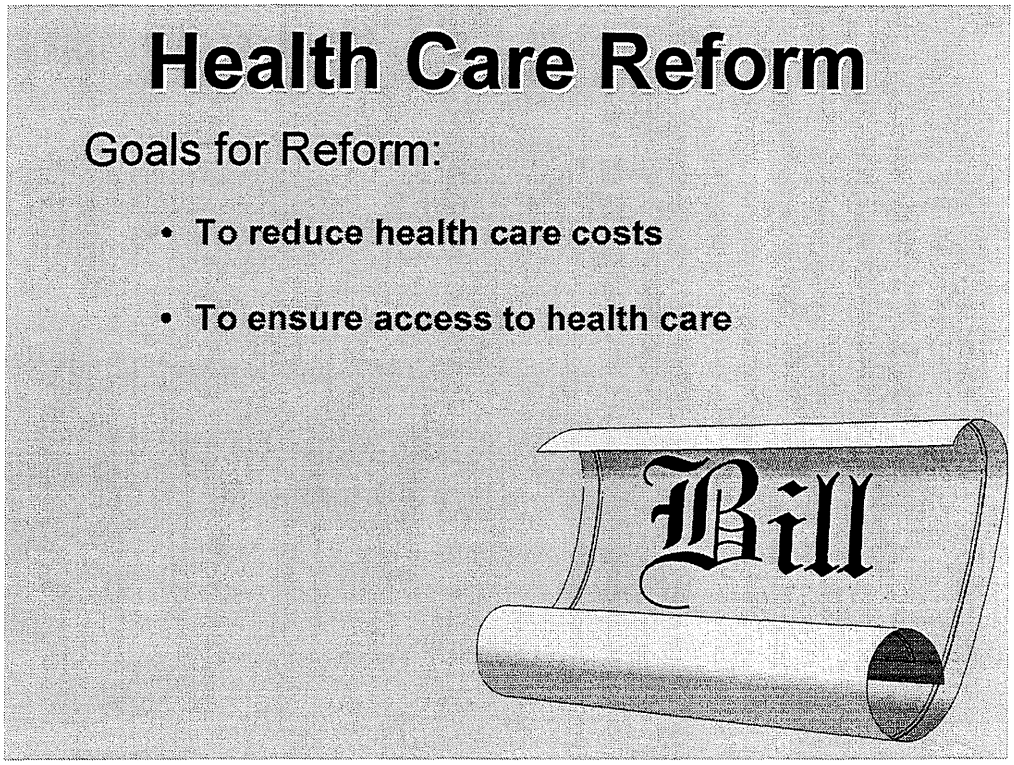


The Changing Environment *(continued)*

According to the U.S. Census Bureau's Current Population Survey (CPS) reflecting 1993 data, approximately 37 million Americans are uninsured on any given day. In Florida alone, as many as 2.6 million people, representing almost 20 percent of the state's under-65 population, may be uninsured.

The uninsured population is a constantly changing group. Many of these people will be without coverage for less than six months. These "short-term" uninsured may be changing jobs, moving, going off welfare, becoming widows, etc. They have probably left some form of employment-based coverage and will soon have coverage again. Far fewer go without coverage for longer periods. The Census Bureau estimates that about four percent of the population are chronically uninsured, going without coverage for two years or more.

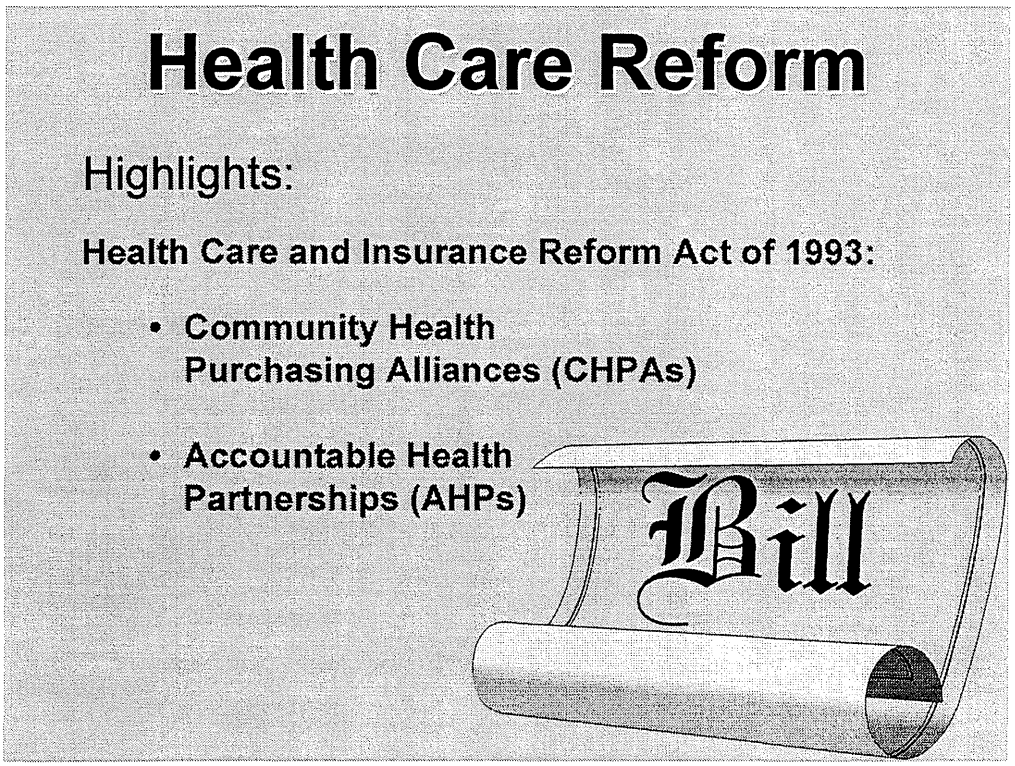
Many of the uninsured are workers employed by small businesses, single individuals or those with low incomes.



Health Care Reform

Rising health care costs, shifting demographic and insufficient access to health care have heralded the need for health care reform. The nation's and Florida's goals for reform have been to reduce health care costs and to ensure health coverage to all who want it.

The Health Care and Insurance Reform Act of 1993 (Senate Bill 1914), known as Florida's "Healthy Homes" plan, was designed to make health care less expensive and available to all Floridians by January 1, 1995. The Florida Legislature passed what many experts call its "landmark health care reform legislation" on April 3, 1993.

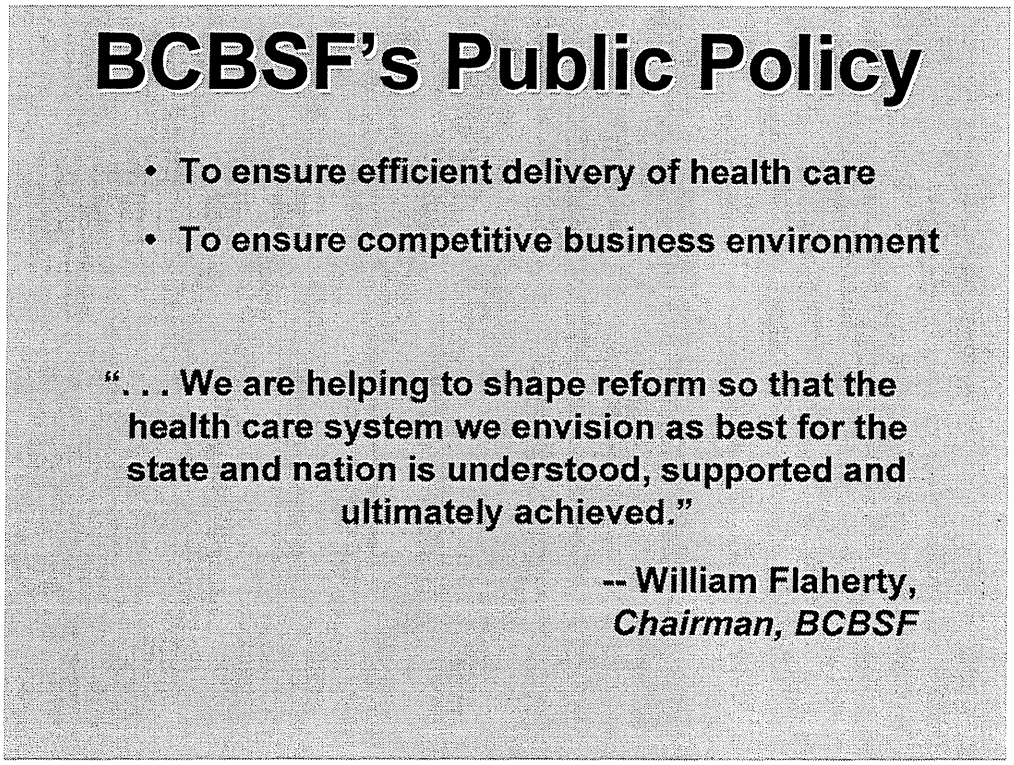


Health Care Reform *(continued)*

Highlights of the new state law are the establishment of :

- ***Community Health Purchasing Alliance*** or ***"CHPA" Program***. Designed primarily to help small employers with one to 50 employees purchase affordable private health insurance. CHPAs are state-chartered, non-profit private corporations that serve as brokers of affordable health plans and bring together a large number of small employers to provide better information and access to a range of health plans. There are 11 CHPA regions in the state of Florida. Others who may be eligible in the future to purchase coverage through a CHPA, if certain legislated requirements are met, are Medicaid beneficiaries, certain low-income Floridians, and possibly state employees. Each CHPA contracts with partnerships made up of insurers, managed care companies and networks of physicians and hospitals, known as AHPs.

- ***Accountable Health Partnerships, "AHPs".*** Health plans certified by the state to participate in the CHPA program. As an AHP, BCBSF offers the state-mandated standard small group insurance products in all 11 CHPA districts. Health Options, Inc., BCBSF's HMO, is participating in at least 10 regions. As a leader in Florida's health care industry, BCBSF supports the intent of this state reform.



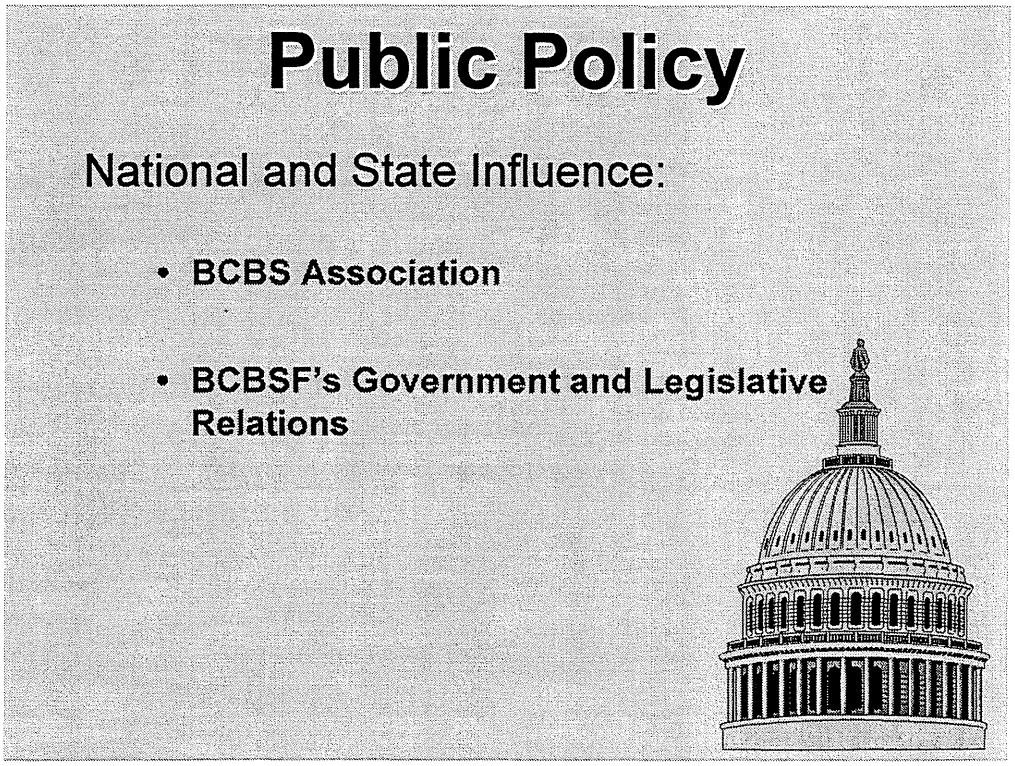
BCBSF's Public Policy

At a national level, BCBSF is actively involved in influencing public policy and reform. Its goals are to benefit society in terms of ensuring:

- the efficient delivery of health care
- a competitive business environment

BCBSF President William E. Flaherty summed up the role that BCBSF plays in legislative and regulatory processes in his address to employees at the 1994 Annual Achievement Awards Banquet:

"In the public policy arena, to the maximum extent possible, we are helping to shape reform so that the health care system we envision as best for the state and nation is understood, supported, and ultimately achieved. We are continuing our involvement in many of the issues being pursued by the Florida Agency for Health Care Administration."



BCBSF's Public Policy *(continued)*

BCBSF is influencing public policy at the national level through its relationship with the Blue Cross and Blue Shield Association. The Association has an office in Washington, D.C., with a staff of 40-plus. The Washington office stays in contact with staff people from the Congressional offices. The goal is to stay abreast of health care issues that may surface in a bill or have significant affect on reform.

BCBSF's officers and employees in the Government and Legislative Relations department represent the company at the national and state levels on issues affecting health care. Under their leadership in 1994, BCBSF initiated a grassroots campaign to influence representatives in Congress that has been implemented in the various states. This work continues today.

Anti-managed care legislation

During the past several years, reforms to reduce costs, improve access and improve quality have been underway. At the end of 1994, federal health care reform initiatives were discarded when Congressional sessions ended without passing reform legislation. Major topics of legislation in 1995 included Medicare reform, Medicaid reform and various proposals that may threaten the future of managed care. BCBSF is actively participating in government affairs to ensure the best outcomes for the American people.

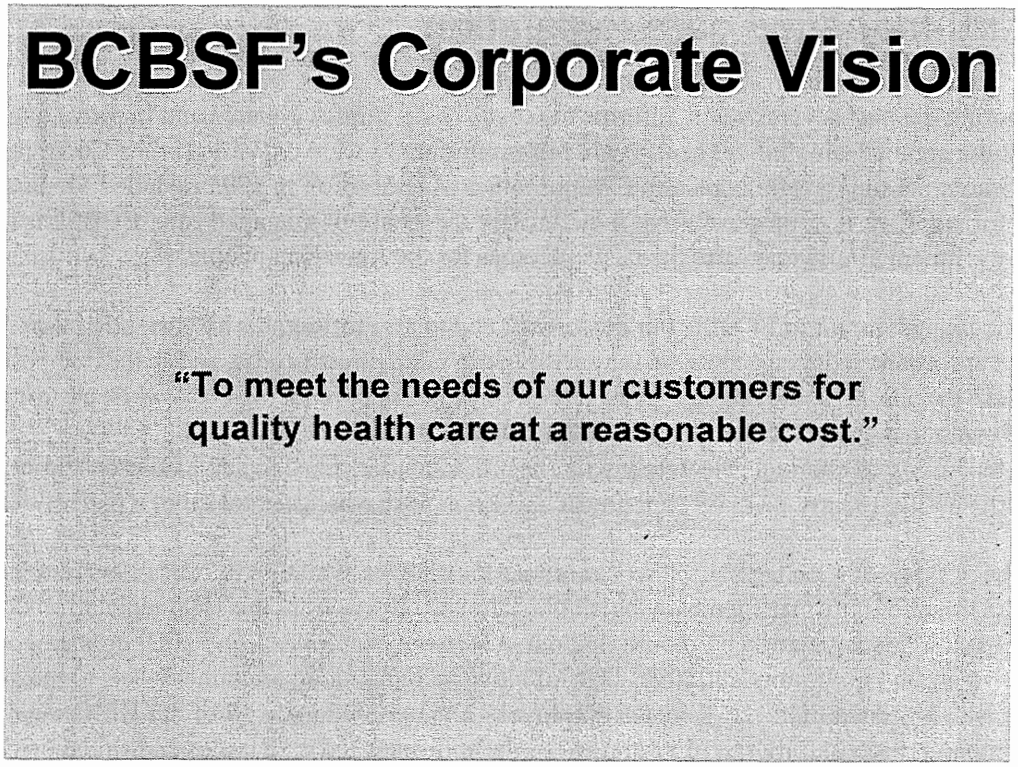
The biggest threat to BCBSF, our customers, and to all Floridians who currently benefit from managed care were the anti-managed care proposals (any willing provider, direct access, and mandated point of service). If passed, these proposals would damage managed care's progress in reducing costs while assuring quality of care by denying managed care companies two very important tools:

- the ability to contract selectively with the providers they need to serve their customers
- the ability to have primary care physicians act as care managers for all of a patient's care

The passage of such legislation would reduce the choices available to consumers purchasing health care coverage. The threat of anti-managed care legislation persisted throughout the 1995 legislative session. BCBSF was able to help stop this legislation by mobilizing our customers, employees, and other concerned Floridians through a concentrated grassroots initiative. This initiative included radio announcements to the general public, telephone calls to key customers and selected employees, and newsletters to all of our HMO members. The grassroots campaign successfully raised awareness of the anti-managed care issues and called on concerned citizens to contact their legislators and voice their opposition to these specific proposals.

On the national level, BCBSF strongly supported the goals of expanding access and controlling health care costs. However, we had serious concerns that components in some of the congressional proposals would not have helped meet these goals. For example, employer mandates to purchase coverage, price controls, mandatory-health care alliances, and a much expanded role for the federal government would negatively affect our customers and all Floridians. Anti-managed care language was also included in some of the proposals.

Throughout 1995, we raised our concerns with the Florida Congressional delegation through direct contact with the delegation and mobilization of our customers and other concerned Floridians. We organized conference calls between business customers and Florida's congressional staff, and we sponsored radio ads to encourage the general public to contact their representatives. In addition, BCBSF provided direct support to BCBSA's lobbying staff in opposing harmful proposals.



Corporate Card

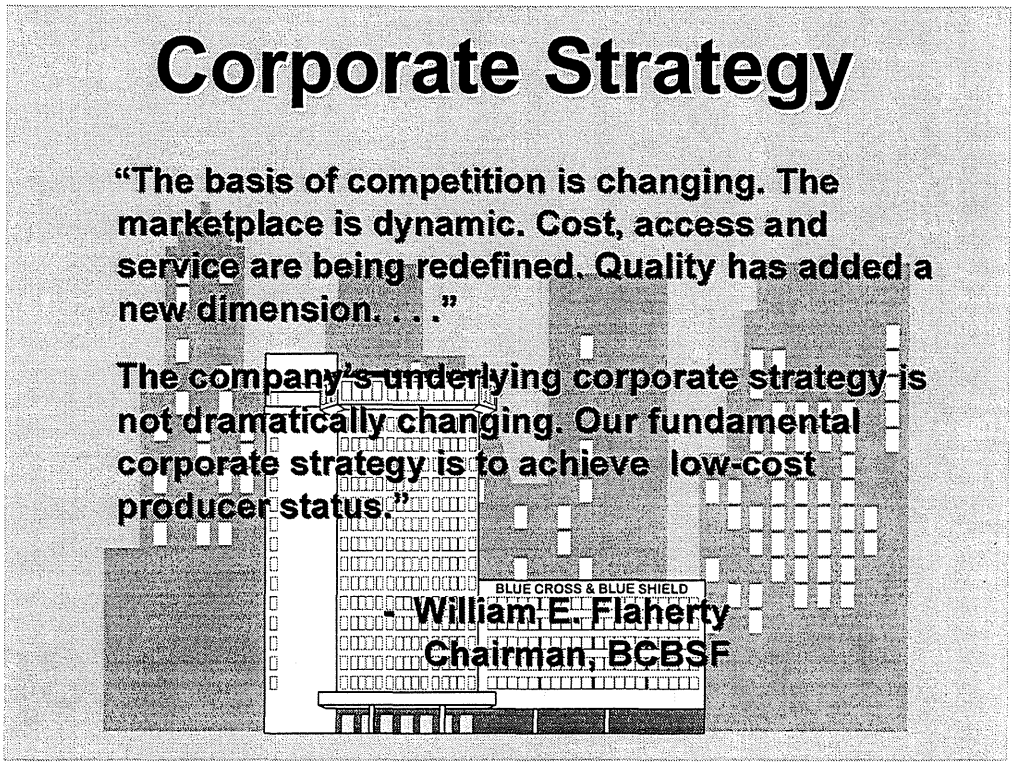
BCBSF's Vision of the Future

". . . In my vision of the future, our company is continuing to lead the way in lowering health care costs, expanding access to more people, and providing caring and responsible service to our customers."

-- William Flaherty
Chairman, BCBSF

Notes

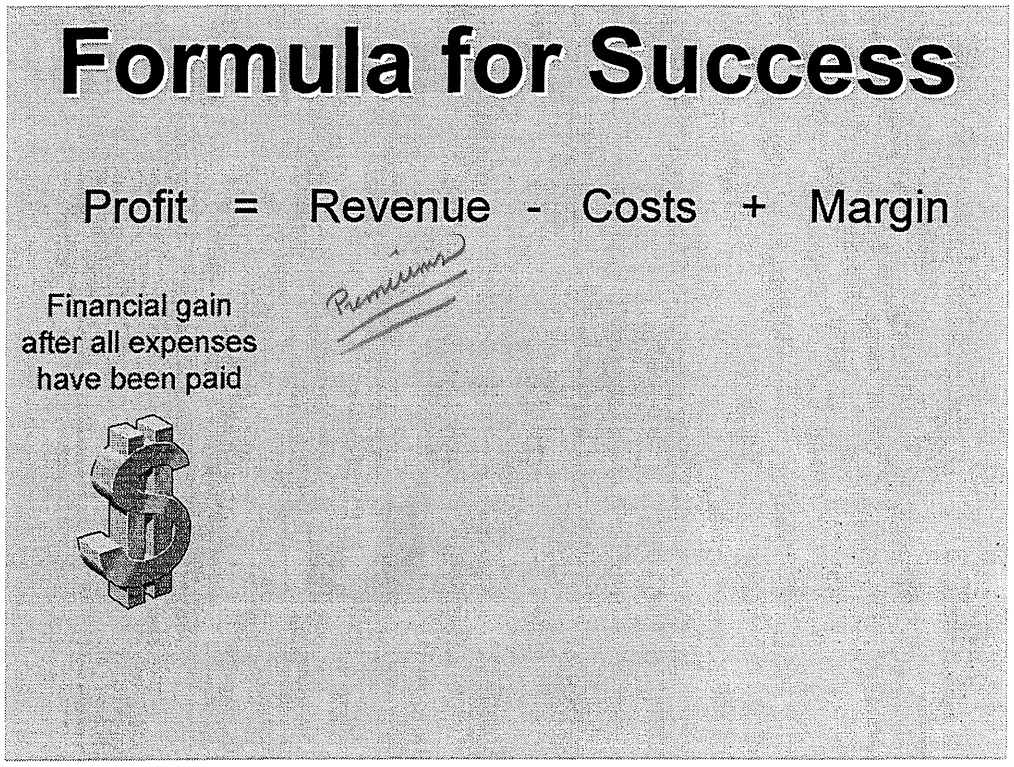
Corporate Strategies



How does BCBSF Compete?

"The basis of competition is changing. The marketplace is dynamic. Cost, access and service are being redefined. . . . Quality has added a new dimension. . . . Quality will be viewed as essential. . . ." These are the words of BCBSF Chairman William E. Flaherty at a 1994 annual Sales/Marketing Conference.

Mr. Flaherty explains, "The company's underlying corporate strategy is not dramatically changing. Our fundamental corporate strategy is to achieve low-cost producer status."

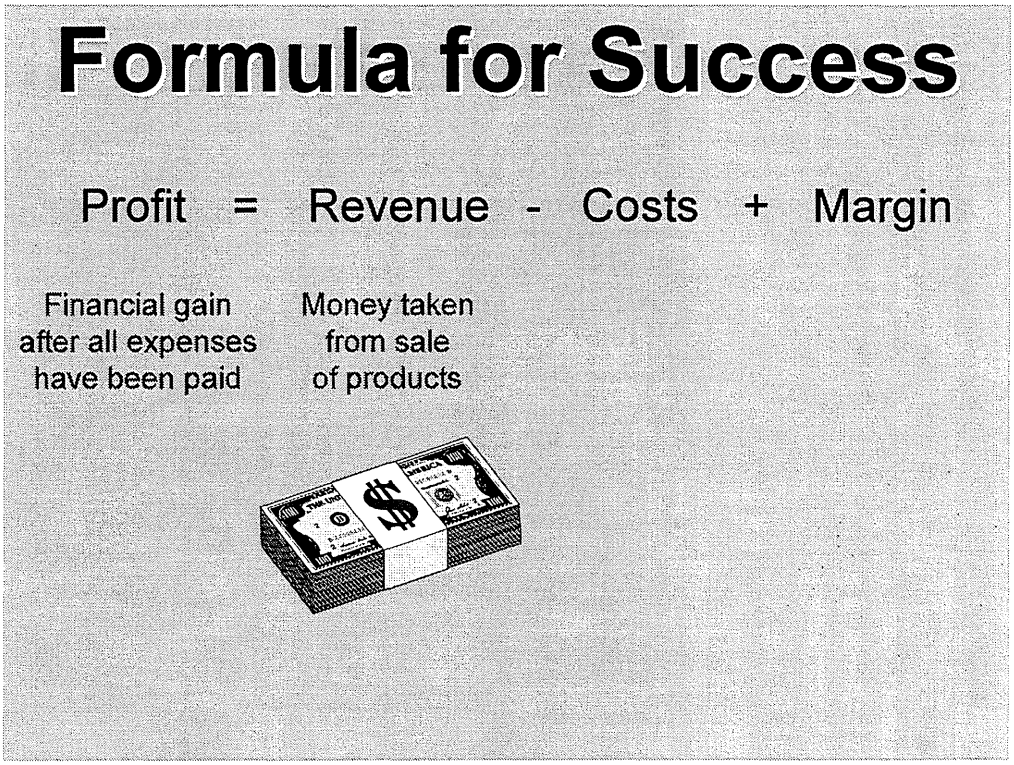


Formula For Success

The formula for success is Profit = Revenue - Costs + Margin

Profit is what keeps a business running. Profit is the business' financial gain after all operating expenses have been met. Firms that habitually take in less money than it costs them to operate eventually will go out of business.

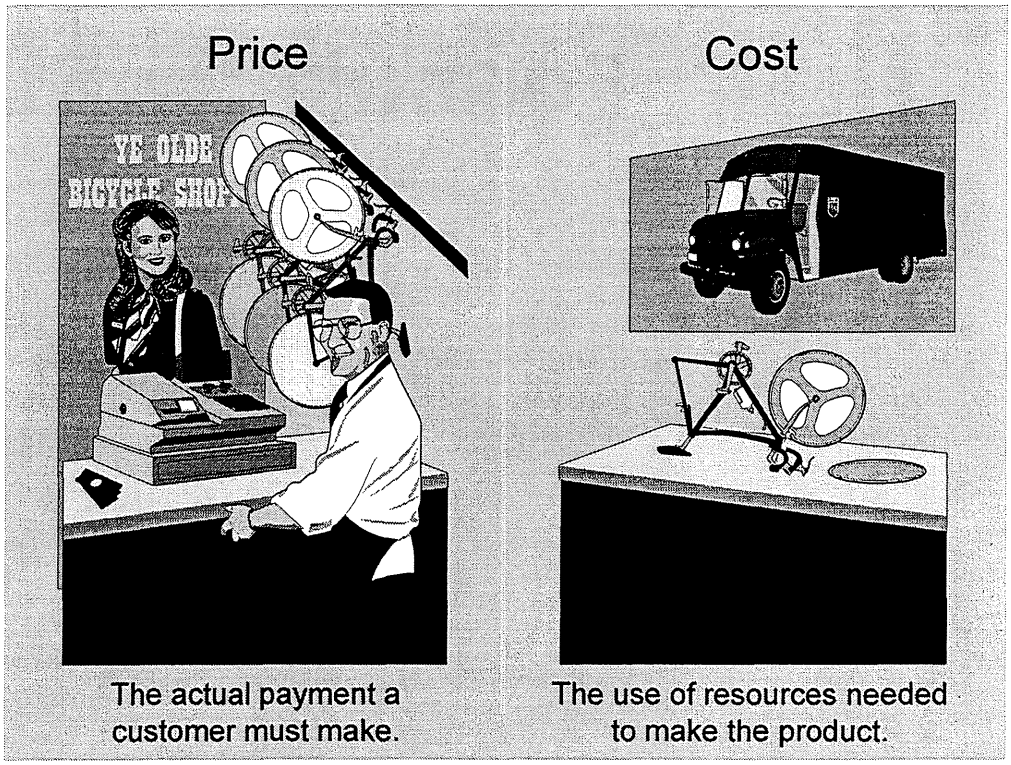
Even though BCBSF does business as a not-for-profit, mutual insurance company (and does not distribute its profits to stockholders), the company must take in sufficient monies to cover its operating costs and to maintain adequate financial reserves to handle any payment it will be called upon to make in fulfilling its promise to a customer.



Formula For Success *(continued)*

The profit equation begins with ***revenue***, or the money taken in by the company from the sale of health care coverage. This money comes in the form of premium payments. Customers pay a certain price for BCBSFs products and services.

It is BCBSF's job to be sure that the amount charged for our products and services (price) is adequate to cover the costs the company will incur in making those products available.

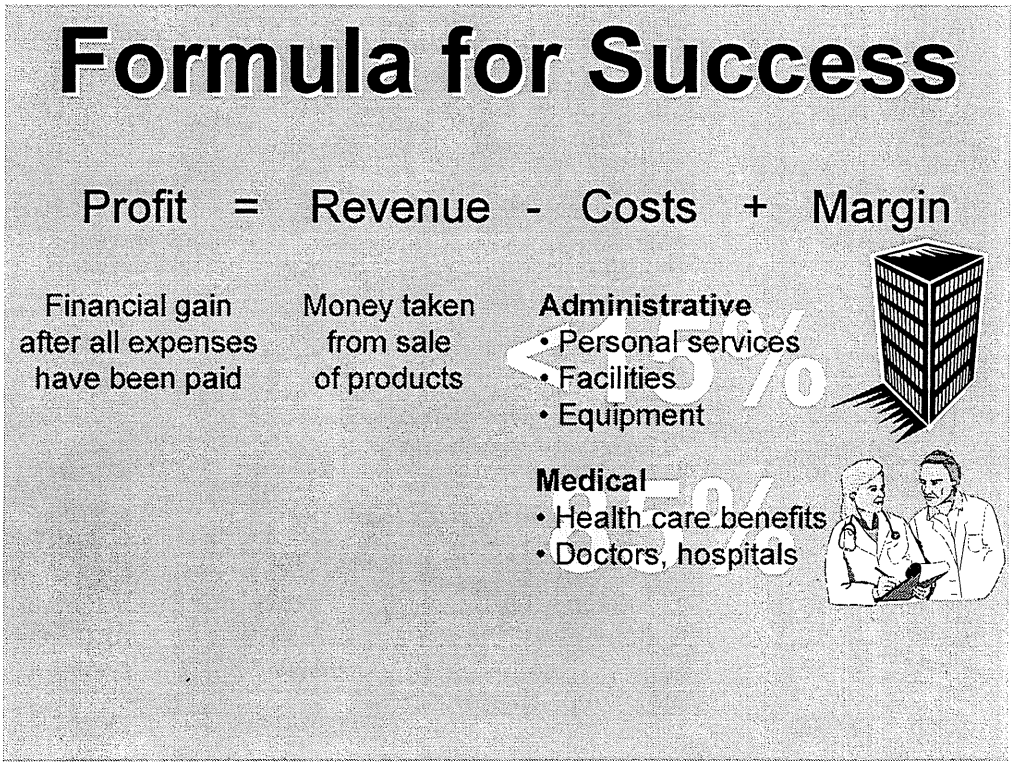


Formula For Success *(continued)*

The next element in the formula is ***cost***. It is helpful to understand the difference between ***price*** and ***cost.***

- ***Price*** is an exchange concept. It is the actual payment a customer must make to obtain the products or services wanted.

- ***Cost*** is a production concept. Cost measures the resources needed to make the product or service and then to deliver the product or service to the customer.



Formula For Success *(continued)*

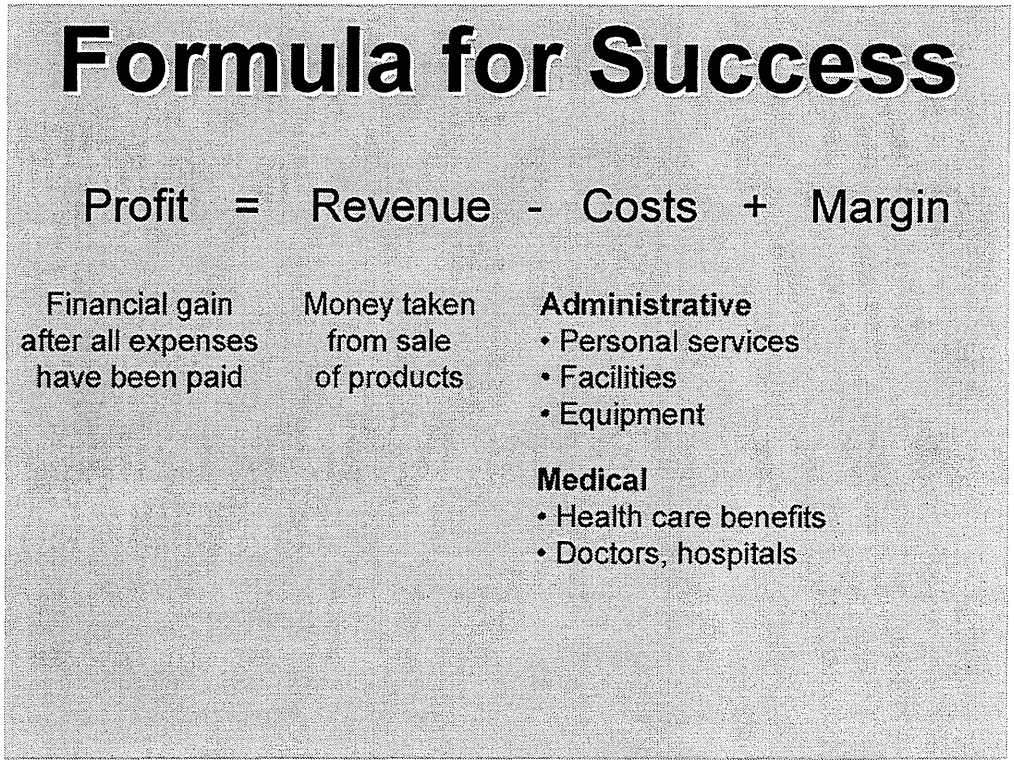
In this formula, there are two kinds of costs that BCBSF incurs as it provides products and services for its customers: ***administrative costs*** and ***medical costs.*** Both of these costs must be subtracted from the revenue.

Administrative costs are expenses related to managing the business. Administrative expenses typically include the cost of staff functions, records maintenance, claims processing and the like. Other examples include the cost of:

- Personal services (salaries, employee benefits, etc.)
- Facilities (buildings, office space, supplies, etc.)
- Equipment (computers, contracts, etc.)

Medical costs are expenses associated with providing health care benefits to our customers. Payments made to physicians, hospitals, and other ancillary providers for the services they deliver to customers under contract with BCBSF are medical costs.

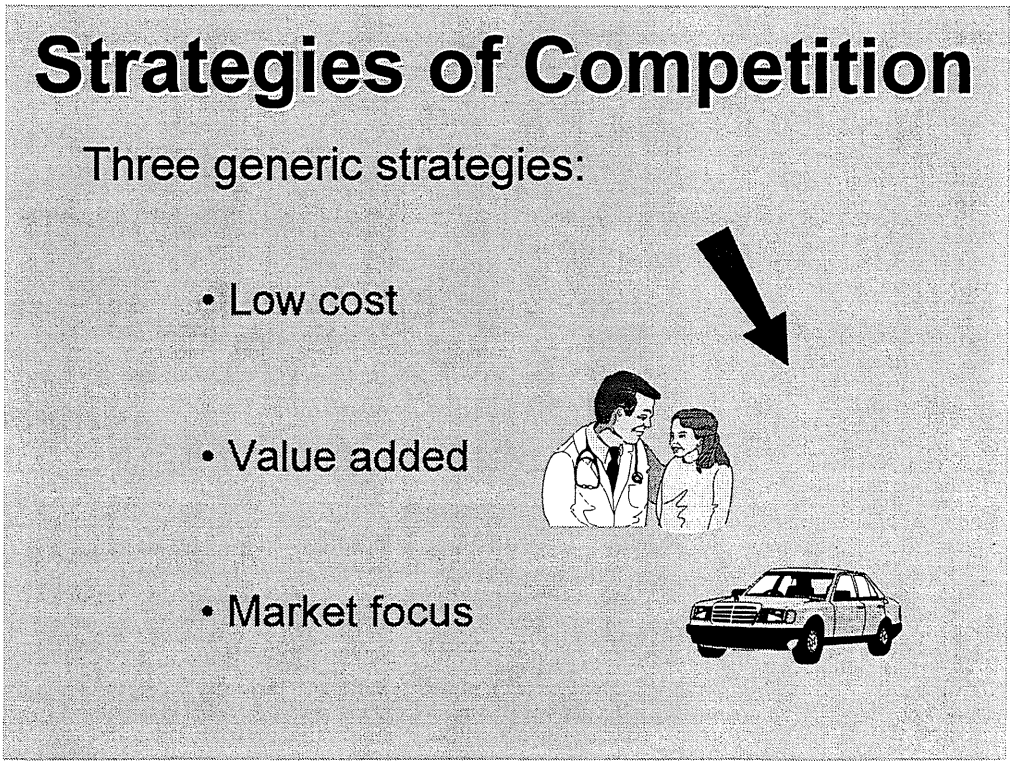
All of these costs are subtracted from the revenue brought in from the sale of our products and services.



Formula For Success *(continued)*

To guarantee that some monies will remain after administrative and medical costs are paid, financial experts factor into the formula what is called a ***margin***. This is the amount needed to create financial ***reserves*** to pay for unforeseen medical costs and to finance research and development. State law requires BCBSF and other health care businesses to maintain a reserve.

Businesses succeed in a competitive environment only if they are able to continue making a profit. Profits can be reinvested in the company to help it maintain its competitive advantage. Competitive advantage is gained by driving down costs, both adminstrative and medical. One of BCBSF's goals is to reduce administrative costs from 15 percent to 5-10 percent.

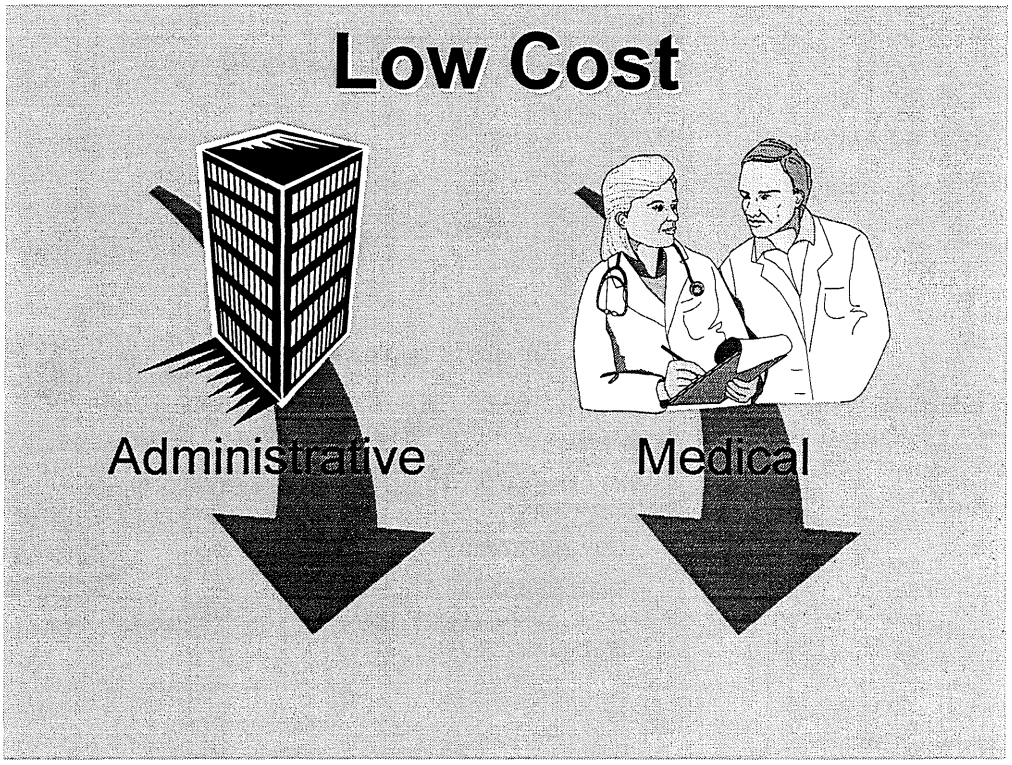


Strategies of Competition

Companies within any industry have choices to make about what strategies they will use to compete in the marketplace. Strategies are forces which a company uses to execute its purpose as efficiently as possible.

There are three generic strategies that any business can use to achieve an advantage over its competitors:

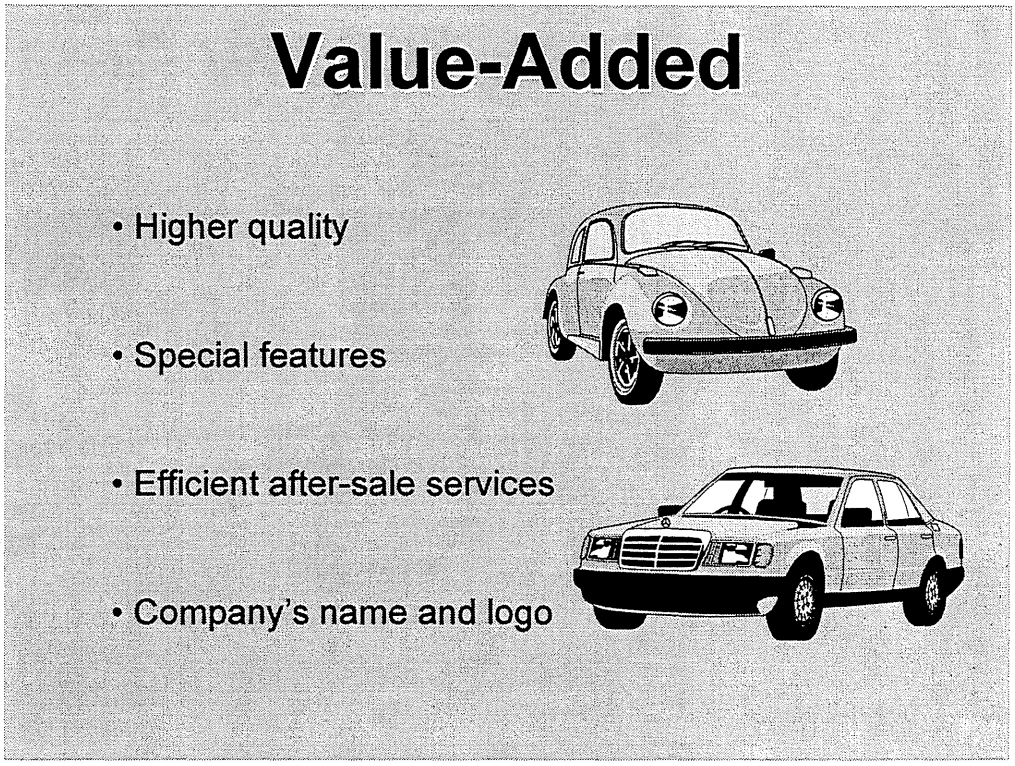
- Low-cost producer
- Value-added producer
- Market focus (or market niche)



Strategies of Competition *(continued)*

Low-cost producer strategy: A low-cost strategy means the company's focus is on its ability to design, produce, market and deliver a product that is more price- competitive than a comparable product offered by competitors. To gain a competitive advantage using this strategy, a company must minimize how much it pays out in costs.

BCBSFs goal is to drive down administrative expenses and to continually implement cost management strategies that minimize medical expenses.

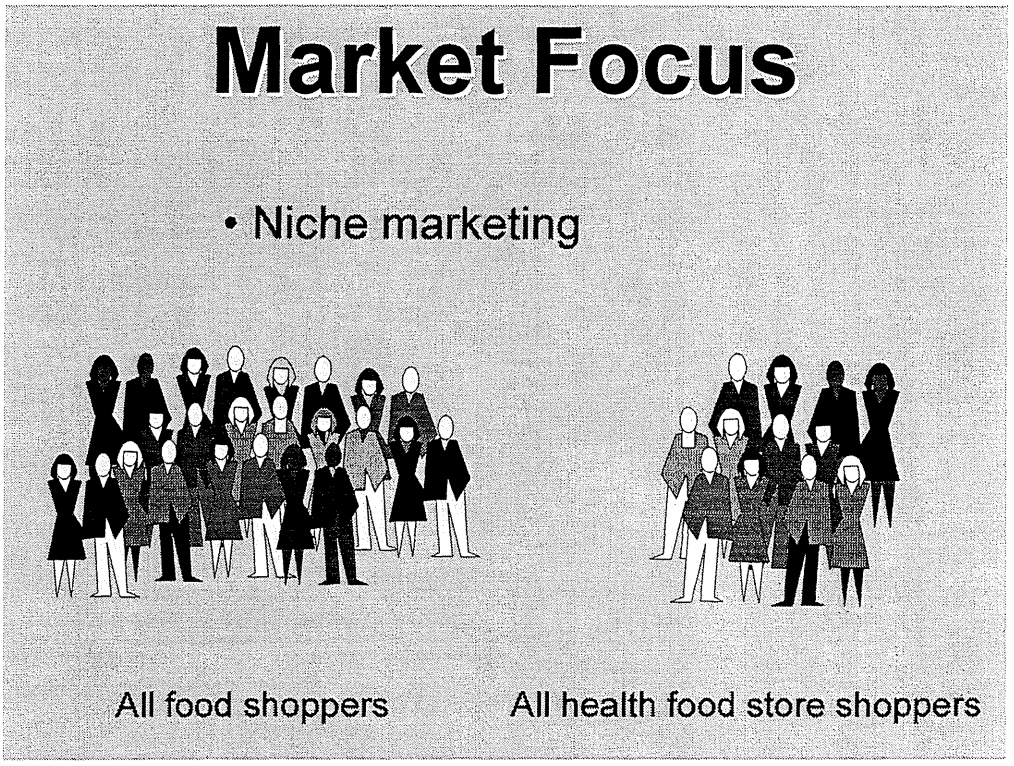


Strategies of Competition *(continued)*

Value-added producer strategy. The value-added strategy differentiates a company's product from that of its competitors by creating a perception of "superior value" in the customers' eyes. Customer perception may be cultivated by the company's ability to provide a higher quality product, special features or efficient after-the-sale service. A customer service representative's courteous answer to a question over the telephone can add immeasurable value to BCBSFs products and services.

A company's trade name and logo can also add value to the product in the eyes of the customer. New entrants into any industry must spend heavily to overcome existing competiton that has created a reputable name over a long period of time.

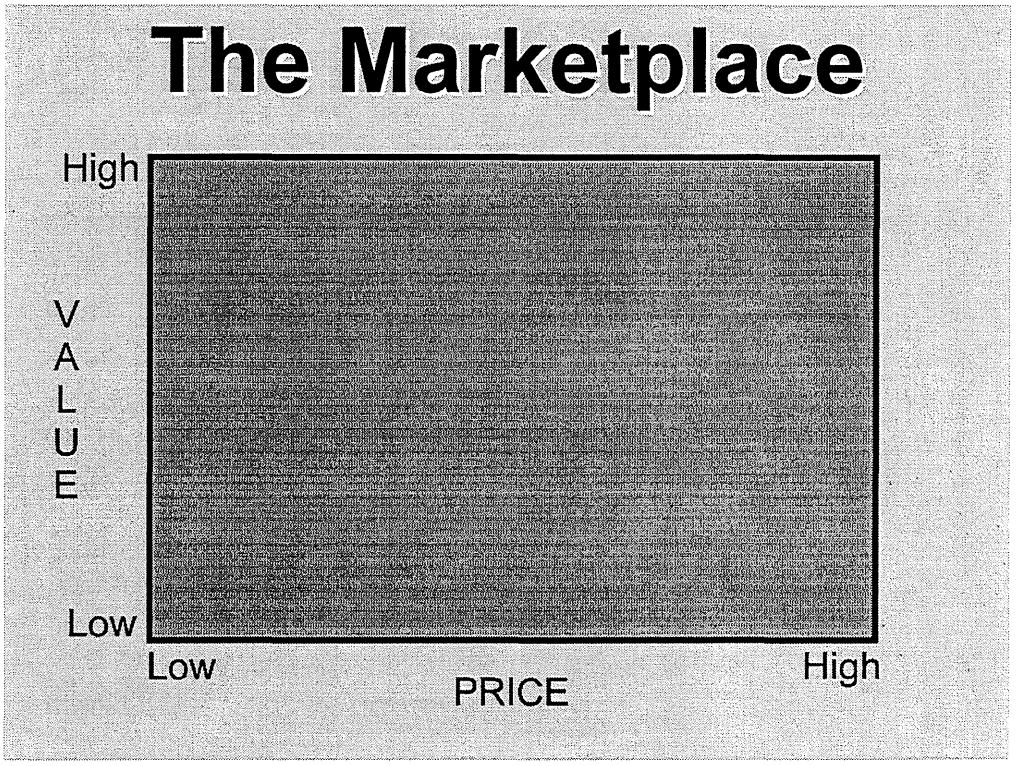
Using a value-added strategy does not allow a business to ignore costs, but there is a strong focus on creating a product that has superior value at a price the customer is willing to pay.



Strategies of Competition *(continued)*

Market focus strategy: The company that uses a market focus strategy specializes in targeting and serving a particular "niche," or narrowed market segment. This company can then conduct its operations more efficiently and effectively than its competitors.

The primary goal is to serve an identified niche well. While competitors spend resources trying to reach a broader market, a narrower scope allows a company to serve the target in a unique way while achieving lower costs.

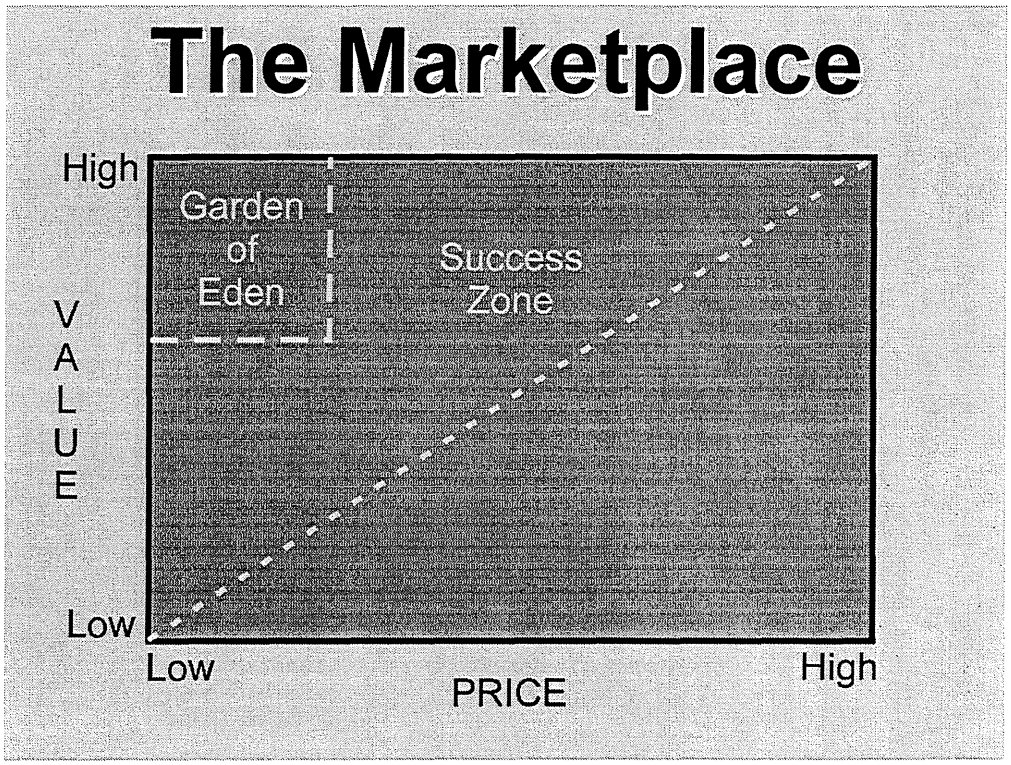


The Marketplace

Let's take these three strategies (low-cost, value-added and market focus) and place them in a "visual" marketplace.

This square represents the marketplace. A company can strategically choose where it will compete in that marketplace based on ***cost*** (which translates into ***price*** for the customer) and ***value.*** That is, the cost of a product can be perceived by the customer as being very low or very high, and its value can be perceived by a customer as being very low or very high.

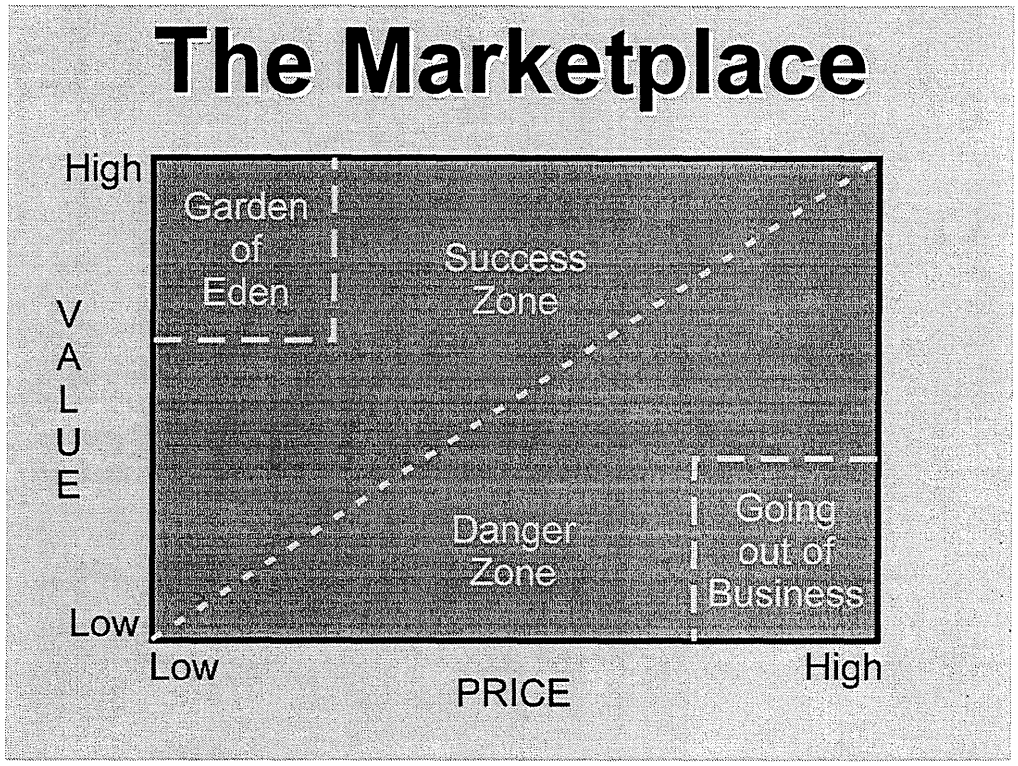
It is important to remember that whether a product is high or low in price or value is based on how the customer perceives that product compared to the other products on the market.



The Marketplace *(continued)*

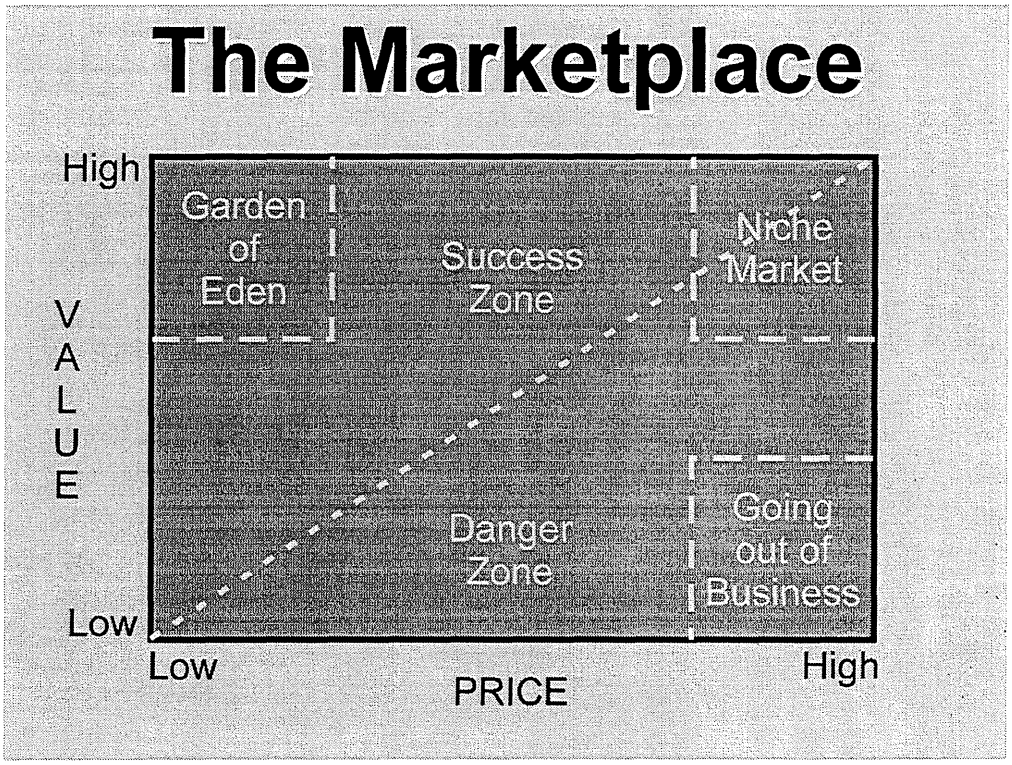
The Garden of Eden: The most ideal position in the marketplace is for a company to offer products or services that are perceived by the customer as being of high value but low-priced. This market position is known as the Garden of Eden or the Success Zone, because the combination of these two strategies virtually ensures success.

Such a value-added, low-cost strategy was adopted by Embassy Suite Hotels, which increased the value of the motel "room" in the eyes of the customer by offering a suite at the same price as a competitor's standard room.



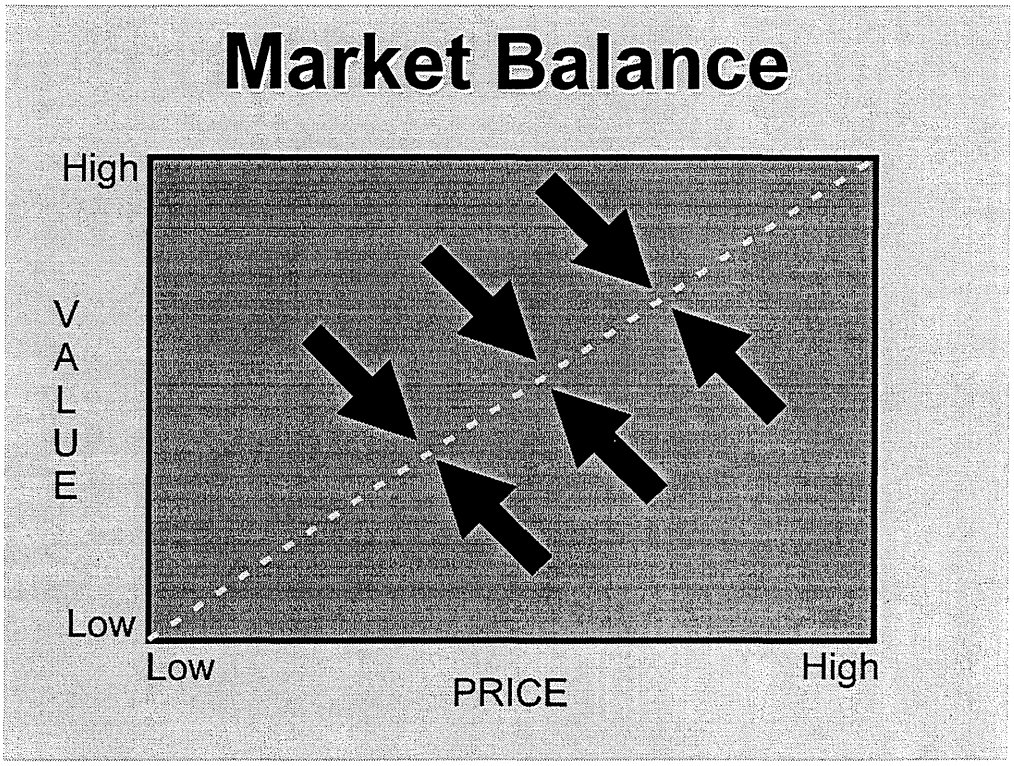
Marketplace *(continued)*

The Danger Zone: The worst position in the marketplace is for a company to be perceived by the customer as producing a high-priced product of low value. This place is known as the Danger Zone, because a combination of high price and low value leads to going out of business. For many years, the Xerox Corporation held a high-price and high value position in the marketplace with its mainframe computers. However, when its competitors introduced the small personal computer, Xerox's large mainframes lost value in the eyes of the customer, yet the price remained high. Xerox experienced a severe threat to its success.



Marketplace *(continued)*

The Niche Marketer: The niche marketer produces specialized products and services for a specific segment of the market. Many niche marketers, for example, operate exclusively in the high price, high value area of the marketplace. In so doing, the company automatically narrows its customer base to those who can afford the high price to obtain the high value. Mercedes is a high-priced vehicle which carries a perception of high value. Only a small percentage of the population can afford the Mercedes, so the company caters to that small piece of the market.

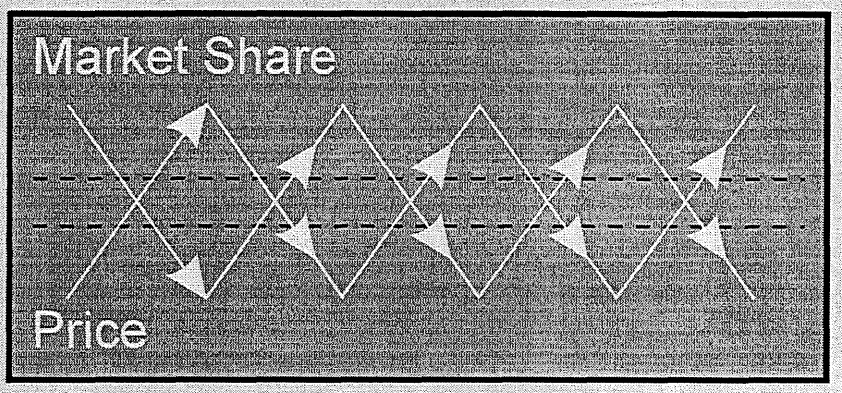


Marketplace *(continued)*

The diagonal line on the graph that separates the safety and danger zones is constantly moving in response to competitive forces in the industry that push against it. Companies that want to survive these forces must be constantly moving toward the Garden of Eden by offering value-added products at low cost.

This accomplishment requires a delicate business balance and is not always easy to achieve on a consistent basis.

Market Share and Price



Market share: Percentage of potential buyers captured by a company

Price: Profit = ***Revenue*** - Costs + Margin

Marketplace *(continued)*

As discussed earlier, the price of a product is what generates revenue for a company. Typically, however, as a company's prices go up, the size of the market share goes down. Market share is the percentage of potential buyers that is captured by a company. Loss of market share can threaten a company's survival. To regain a market share, the company must lower its prices.

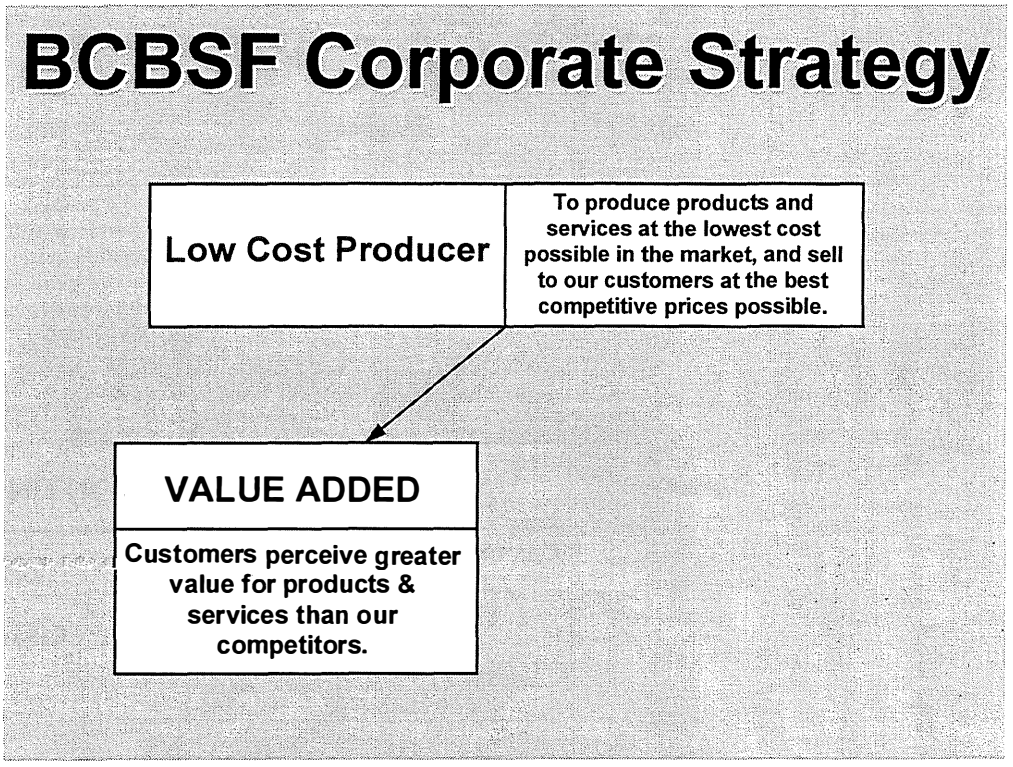
This illustration represents the balance companies must reach in obtaining and retaining market share and generating enough revenue to stay profitable. The objective of any company is to maintain equilibrium between market share and price.

The band in the illustration represents the product portfolio offered by the company. The bigger the product portfolio offered by the company, the larger the market share, or percentage of customers who may purchase those products.

BCBSF's Corporate Strategy

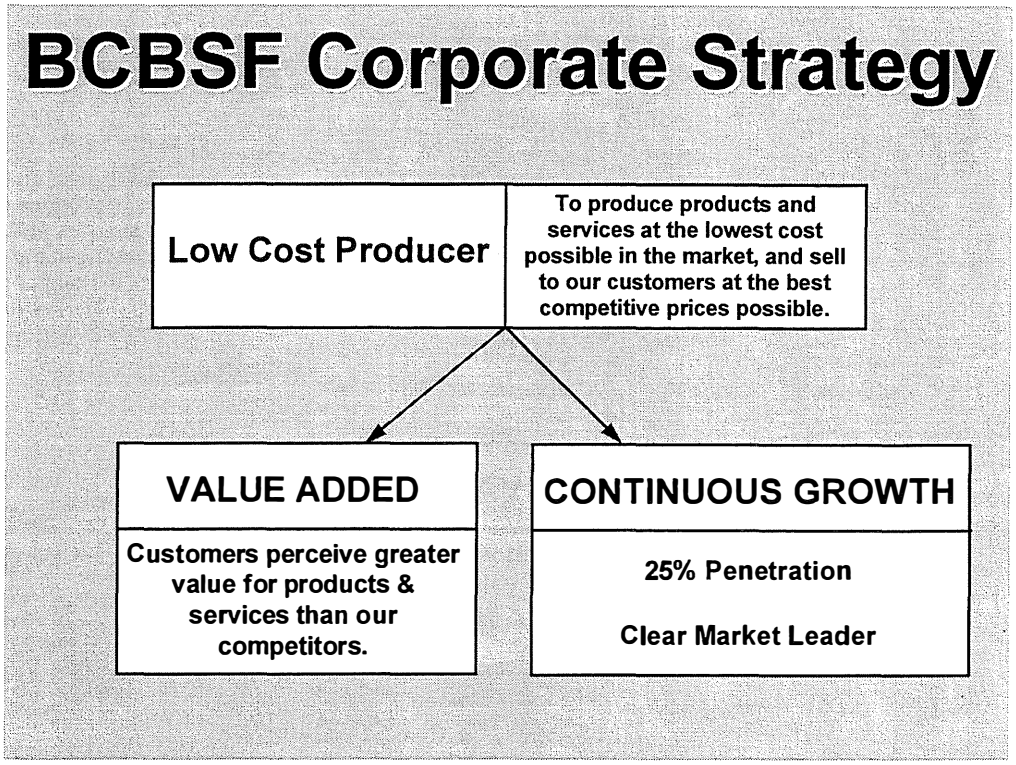
Low Cost. The BCBSF Corporate Strategy emphasizes a low-cost producer strategy and a value-added strategy. Mr. Flaherty explains: "We want to produce our products and services at the lowest cost possible, then turn around and sell to our customers at the best competitive price possible—which is really in terms of [our customer's] view of value. . . . it includes added value features truly appreciated by the customer. . . . We know that the best price in the competitive market is not always the lowest price. Rather, it is that value proposition as determined by the market."

Our overarching strategy to be the low-cost producer requires us to look at our total costs — the cost of operations, administration and medical sources.



BCBSF's Corporate Strategy *(continued)*

Value Added. Value is what buyers are willing to pay. Value stems from either offering lower prices than competitors for equivalent benefits, or providing unique benefits that make paying the higher price "worth it." If a product is perceived as "not acceptable" by customers, a cost leader may be forced to discount prices well below that of competitors in order to gain sales. This may negate the benefits of maintaining a "low cost" position. So, equally important to low cost is value added – that is, the features that help our customers perceive our products and services as having greater value than those of our competitors.



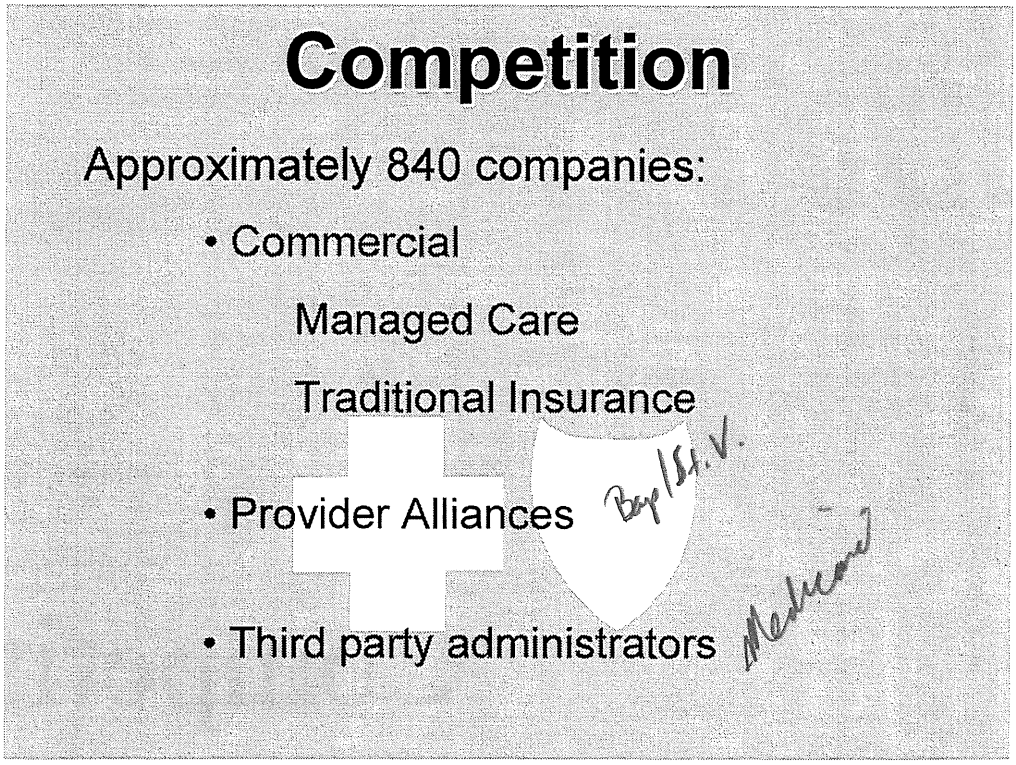
BCBSF's Corporate Strategy *(continued)*

Continuous Growth. We must continually build upon our current market position in Florida so that the company is positioned as the clear market leader, maintaining the number one or number two market position in specific segments of the market and expanding our capabilities to enter or exit any market "niche" we deem as attractive.

Expressed in terms of goals: we will achieve 25 percent market penetration by the year 2000, increasing our current customer base of 1.9 million members to 4.0 million.

Notes

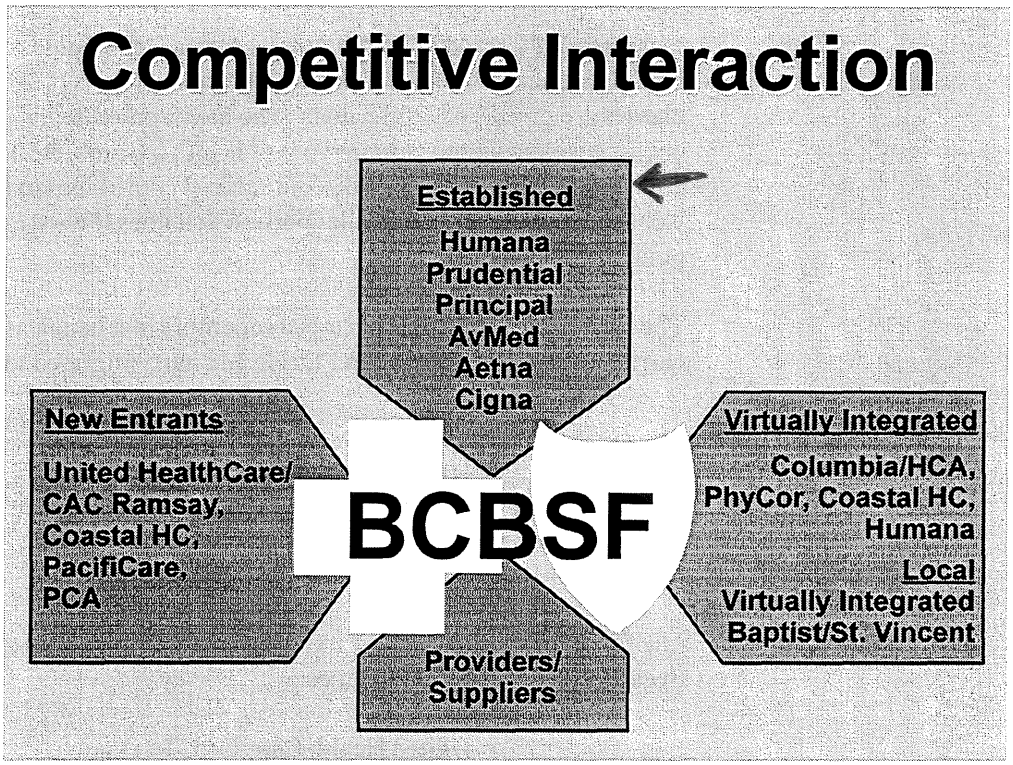
Competition



Competition

Currently there are approximately 840 companies selling health insurance/managed care products in Florida. Much of this competition is from commercial carriers, which include traditional insurance companies that are rapidly gaining experience in the managed care arena, as well as managed care companies, both large and small, entering the market.

Some new forms of competition include provider and hospital alliances, along with large national players seeking to grab marketshare of Florida's attractive over-65 market. Third party administrators — companies that provide administrative services only between the insurer and the policy holder — also compete with BCBSF for our government programs.



Types of Competitors

As we enter new markets and offer new products, the scope of who we compete with enlarges. Conversely, companies with no history in health care are expanding into health care, creating more confusion and uncertainties in the industry.

Blue Cross and Blue Shield of Florida holds approximately 18 percent share of the Florida market. That figure may not sound very high, but, in fact, the next closest competitor, Humana, has about six percent of the market. Overall, all inclusive numbers are difficult to determine; it is easier to determine market share on a product-specific basis.

The trend in health care today is a move to managed care. In contrast to traditional indemnity coverage, products such as Health Maintenance Organizations (HMOs) and Preferred Provider Organizations (PPOs) are experiencing the most growth.

Types of Competitors

Commercial Carriers: Commercial insurance companies are for-profit firms that sell health insurance to those "risk classes" from which a profit can be expected. (Risk classes are groups of subscribers who have something in common: a certain type of coverage, exposure to certain types of health hazards, etc.). With commercial companies, a portion of the money received contributes to the corporation's profits. Consequently, there is a smaller portion that goes toward extending customer and policyholder benefits.

The following companies are top competitors that began as traditional insurance carriers with a long history in Florida and have migrated to the managed care market.

- Prudential
- Humana
- Principal
- Cigna
- Aetna

The following companies are newer entrants to the health care market who began their lives as managed care companies:

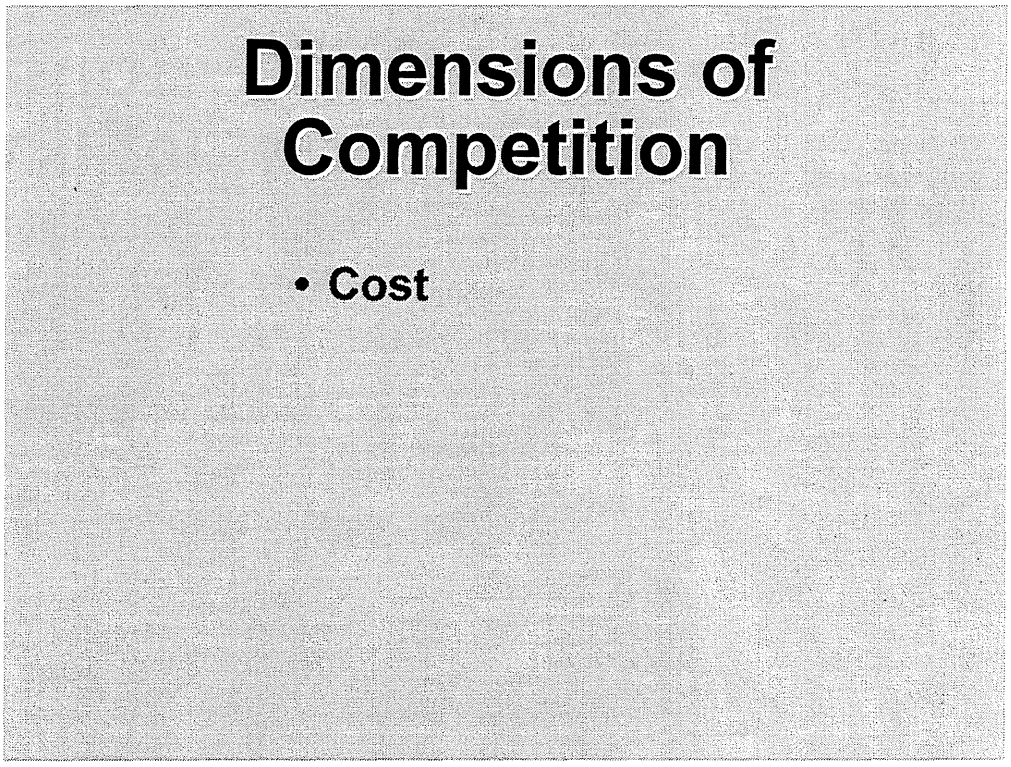
- United Health Care/CAC Ramsay
- Physician Corp. of America (PCA)
- AvMed
- Phycor
- PacifiCare

Providers: Today, physicans, hospitals, skilled nursing facilities and other health care entities are forming alliances that enable them to contract for and deliver health care services to a customer base. These organizations are frequently developed for the purpose of contracting with, or in some cases competing against, managed care plans.

Sometimes, a hospital that provides services for BCBSF customers may also become a competitor. For example, Baptist Medical Center is marketing a health care product to businesses in Jacksonville.

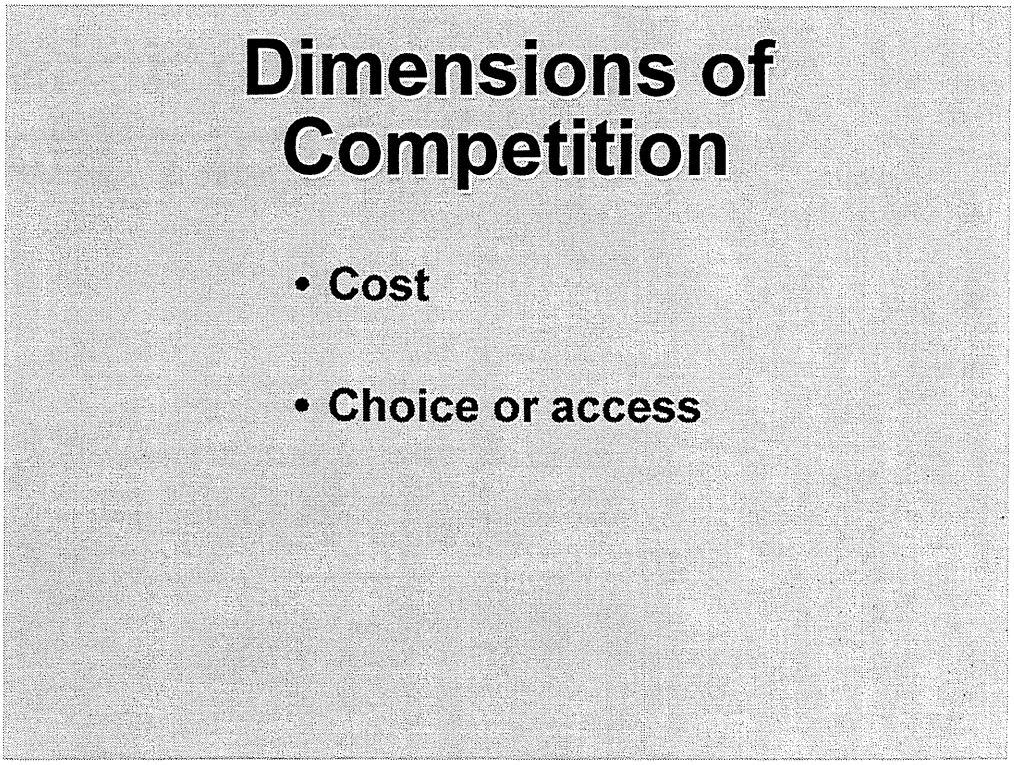
Third Party Administrators (TPA): Third party administrators are companies that provide administrative services only between two other parties — the "insurer" (which carries the risk) and the policyholder. For example, BCBSF is a third party administrator of the government's Medicare Part A and B programs for Florida beneficiaries.

Although BCBSF is the exclusive TPA for Medicare Part B services, Aetna Insurance and Mutual of Omaha are third party administrators of the Medicare Part A program in some areas of Florida.



Dimensions of Competition

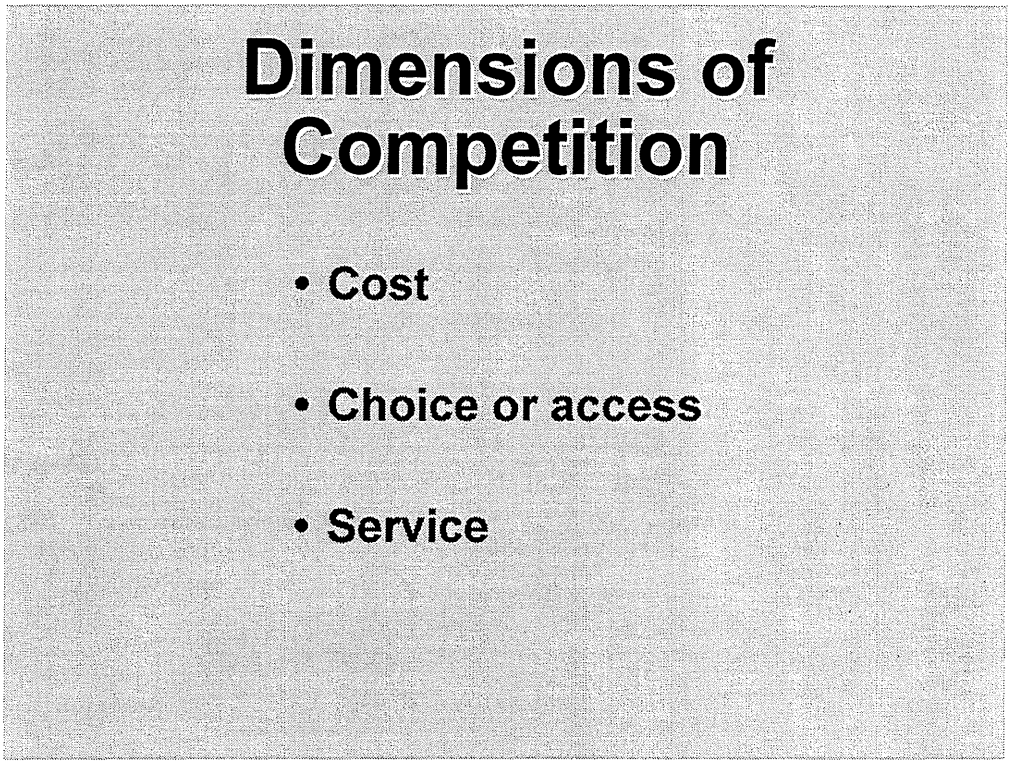
Cost. Cost has always been a basis for competition. But dramatic increases in health care costs have prompted customers to "shop around" to determine whether the rates they are paying for a desired level of coverage or service are the best available. A low-cost position can give a company an advantage over its competitors if customers perceive that they are receiving high value for their money. BCBSF has held cost increases well below the national medical inflation rate.



Dimensions of Competition *(continued)*

Choice or access. With an increasing number of uninsured and underinsured people, access to health care has become a critical issue. In years past, a health insurance policyholder could go to the doctor of his/her choice and expect that health care services would be paid for according to the terms of the traditional insurance contract. But with the introduction of cost-containment initiatives such as managed care programs, "choice" has become a weighty consideration for consumers who are selecting a health care plan.

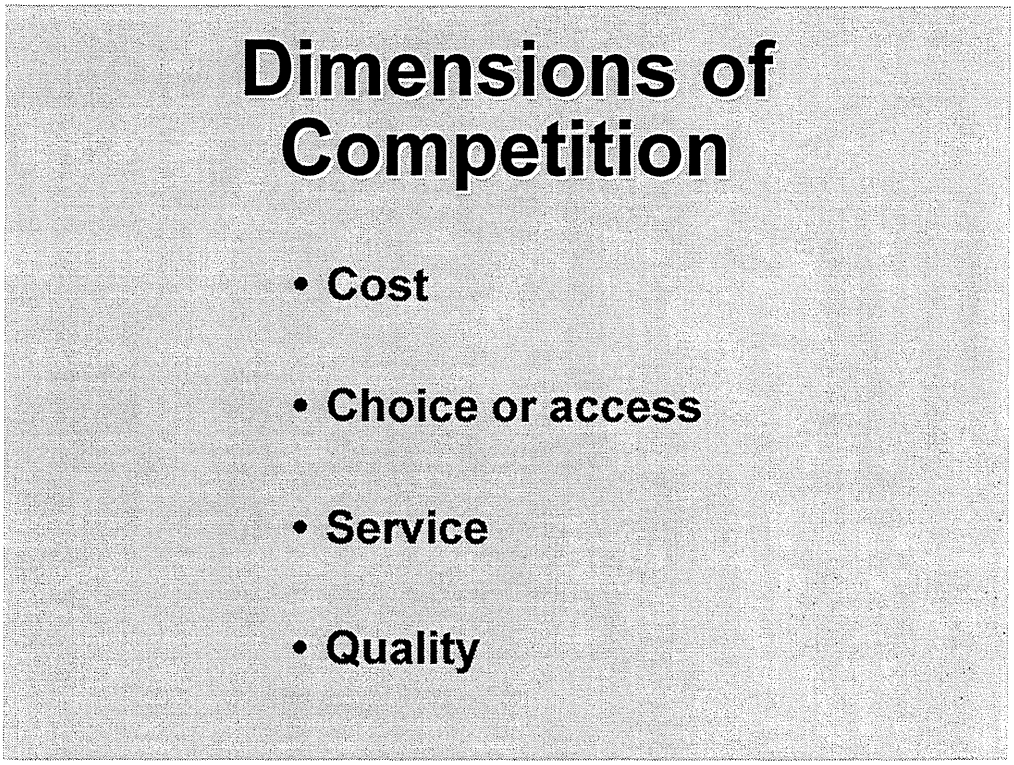
The most essential element in managed care programs is the selection of the numbers and kinds of physicians and providers who can best serve the target population. For the patient, enrollment in a managed care program entails a sacrifice of some choice of provider for the lower cost and greater assurance of quality that managed care plans achieve. For companies competing in the marketplace, choice (or access) becomes an important element that must be factored into the development of new products.



Dimensions of Competition *(continued)*

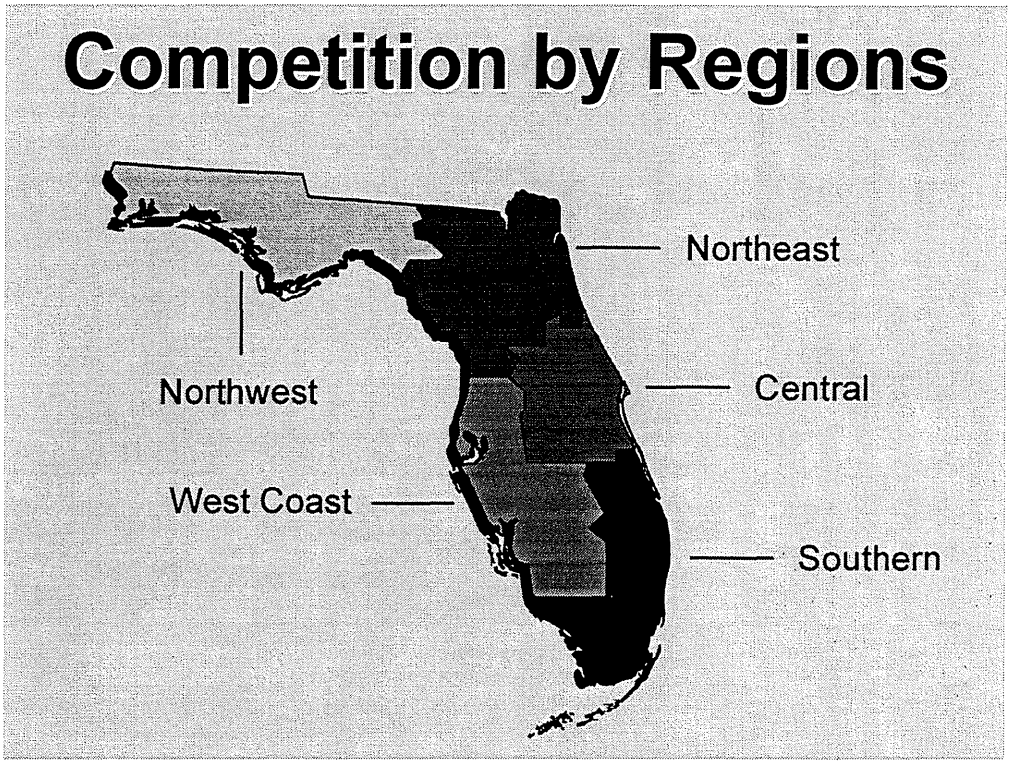
Service. Customer service is a critical element of competition. How a company treats its customers and delivers that "special" service can make the difference in whether or not the company survives the rivalry of its competitors. Service is an area where a company can create an advantage over their competitors, while trying to keep costs down.

Customer service means efficiently helping members with problems, courteously handling grievances and complaints, and tracking and reporting patterns of problems encountered in an effort to continually improve.



Dimensions of Competition *(continued)*

Quality. Quality of care has increasingly become a dominating factor in competition as cost containment measures and limited access become more and more prevalent in health care. Consumers want to be certain that qualified physicians are delivering effective and appropriate health care procedures that will produce a particular health outcome. In managed care programs there must be mechanisms in place for members to seek review of the quality of their care. Other quality issues center around how long the consumer must wait for a doctor's appointment, or how long it takes for a prescription to be filled.

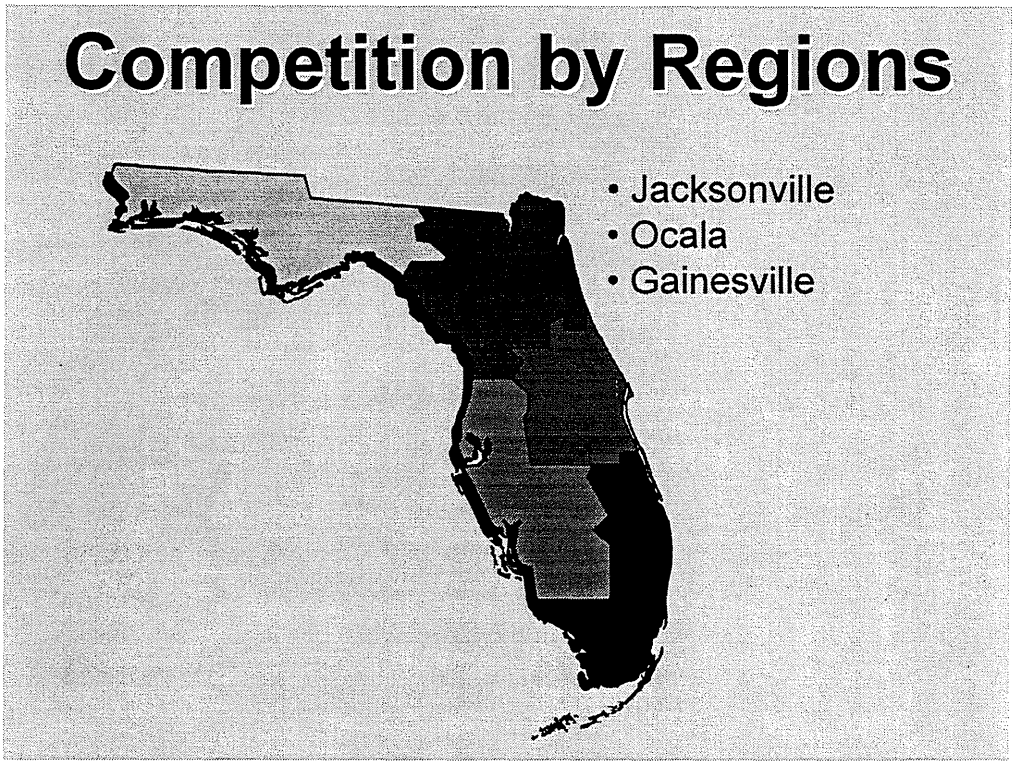


Competition by Regions

BCBSF has divided the state into five separate regions: Northeast, Northwest, West Coast, Central, and Southern.

Generally, within each region, there are at least two or three distinct markets. (For example, Northeast Florida has three distinct markets: Jacksonville, Ocala, and Gainesville. South Florida has also been divided into three distinct markets: Dade, Palm Beach, and Broward.) Because of the mix of providers and competitors in these counties, BCBSF must provide different products and conduct business in slightly different ways in each region and in the markets within each region. The demographics, or the population characteristics of each region, are factors that influence competition.

BCBSF's market research department periodically publishes profiles on all the major competitors in each region.



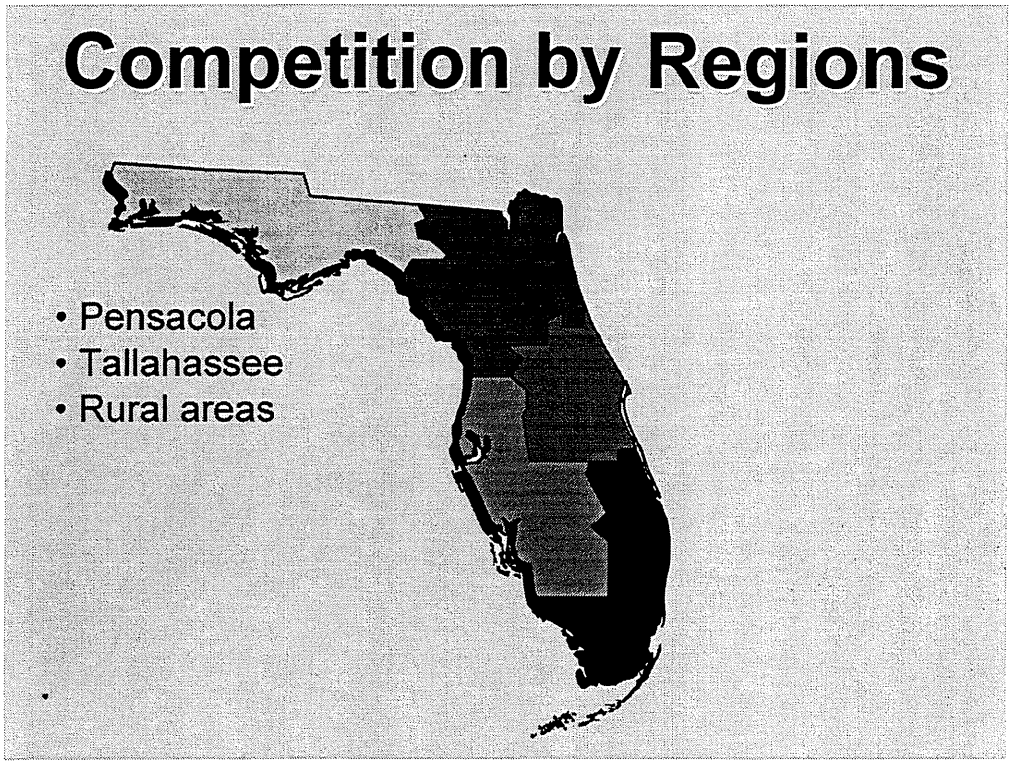
Competition by Regions *(continued)*

Northeast:
Office Locations: Jacksonville and Gainesville

The Northeast region serves 18 counties that fall into three distinct demographic areas:

- Jacksonville (13 percent of the population is over 65)
- Ocala (rural)
- Gainesville (large medical center)

In the Northeast region, HMOs are not a competitive force except in Duval County, and are almost non-existent in rural counties. The top five competitors are Principal, Prudential, Av-Med, Great-West and Humana.

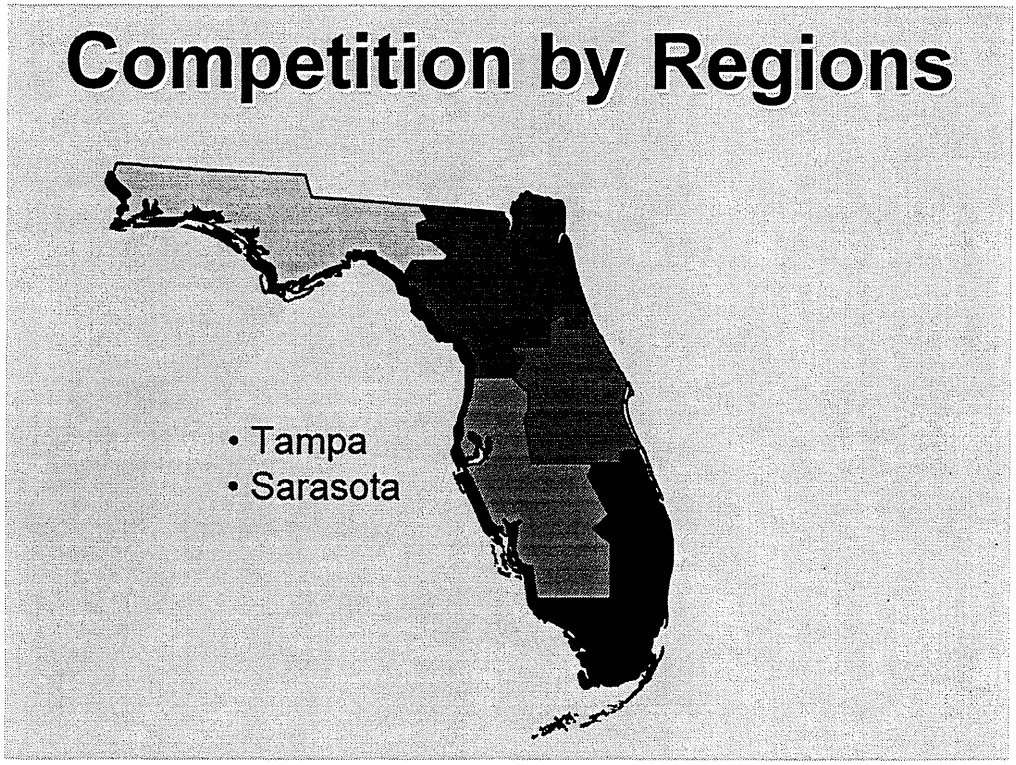


Competition by Regions *(continued)*

Northwest:
Office Locations: Pensacola and Tallahassee

The Northwest region serves these demographic areas:
- Pensacola
- Tallahassee
- Rural areas

This region is primarily rural, and managed care is only now just coming into the arena. Competitors see Principal as offering the best PPO, and perceive Humana as a leading HMO provider.



Competition by Regions *(continued)*

West Coast
Office Locations: Tampa and Sarasota

The Northwest region serves these demographic areas:
- Tampa
- Sarasota (40 percent of the population is over 65)

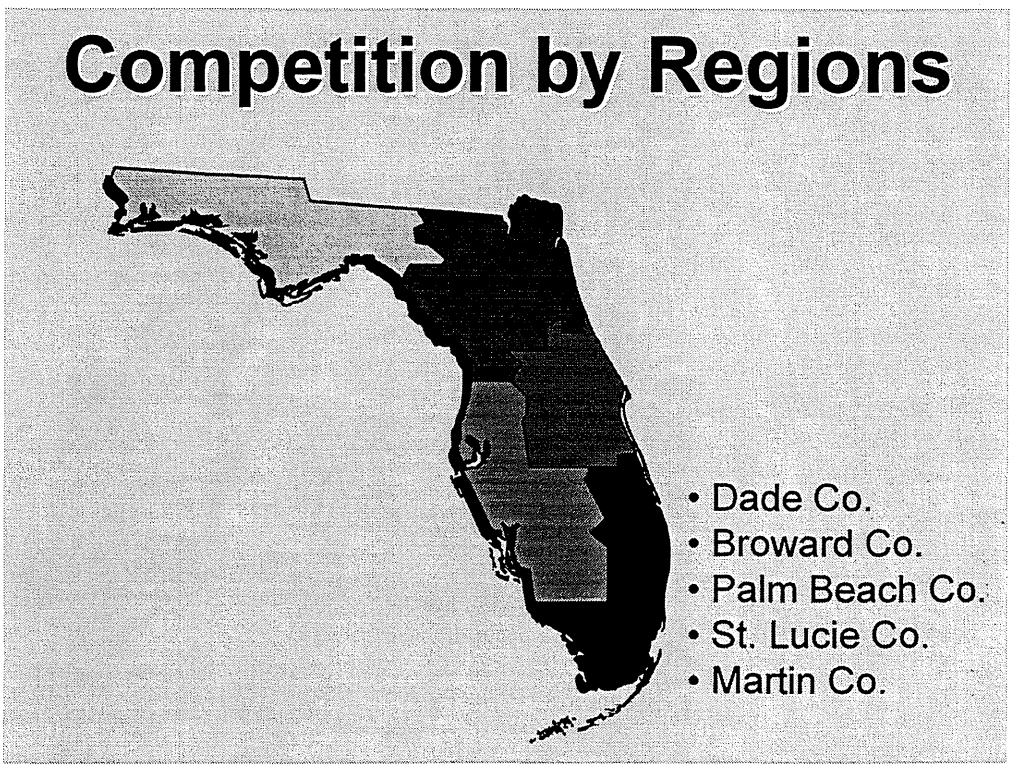
Cigna, headquartered in Tampa, is BCBSF's top competitor in this region. Other carriers with significant market share in this region include Prudential, Principal and Humana.

Competition by Regions *(continued)*

Central:
Office Location: Orlando

The demographic areas of the the Central region include:
- Orlando
- Lakeland
- Rural areas

Top competitors in the Central Region include Humana, Principal, United Healthcare/CAC Ramsay and Prudential.



Competition by Regions *(continued)*

Southern
Office Locations: Miami, Fort Lauderdale, West Palm Beach

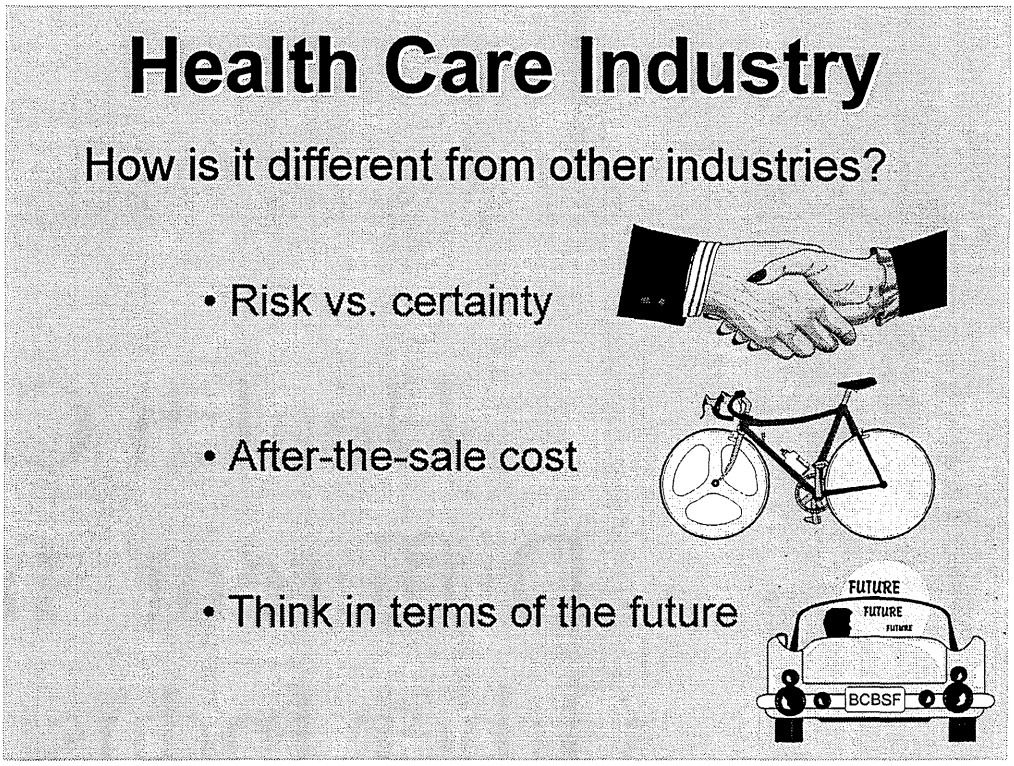
The Southern region serves:
- Dade County
- Broward County
- Palm Beach County
- St. Lucie County
- Martin County

The Southern region is almost entirely urban and is an ideal setting for managed care. Because of this, HMO competition is stiff. Humana has positioned itself in the Medicare HMO market very effectively. PCA has made a name for itself in the Medicaid HMO segment. John Alden has emerged as a competitor through its joint venture with Dimension HMO. Other major competitors include United Healthcare/ CAC Ramsay, Prudential, Principal, Av-Med and Cigna.

Notes: _____

Notes

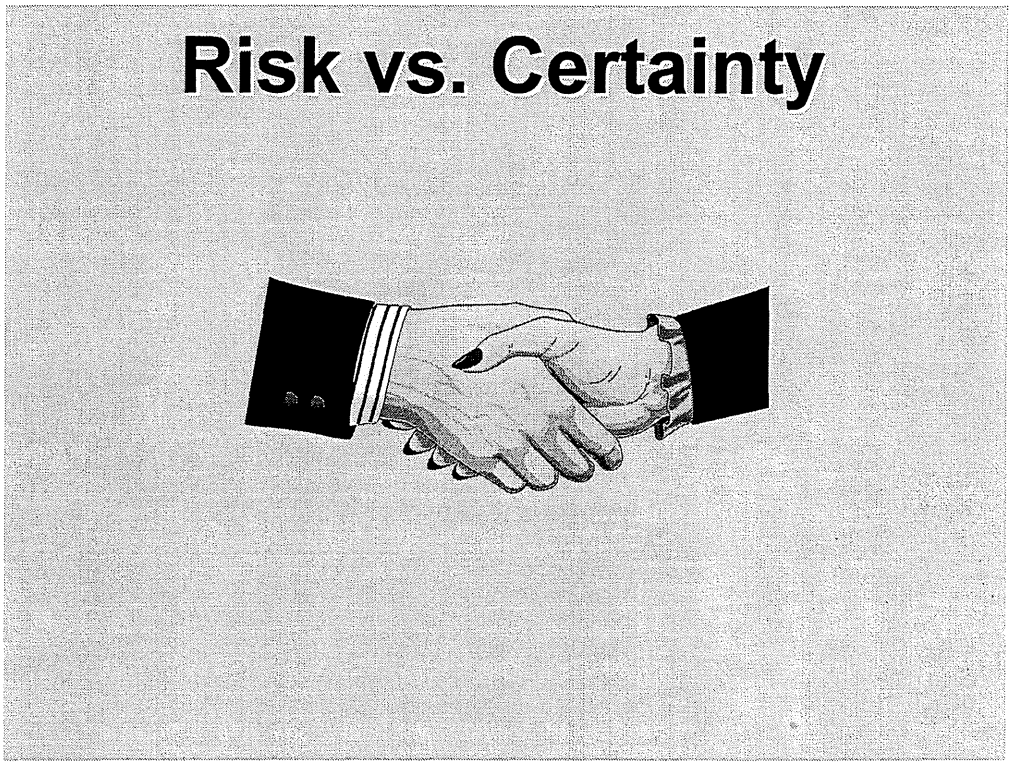
Health Care: Different from Other Industries



Different from Other Industries

Some unique "ways of thinking" govern the way business is conducted in the care management and health insurance industry. These fundamental concepts make these businesses different from many others.

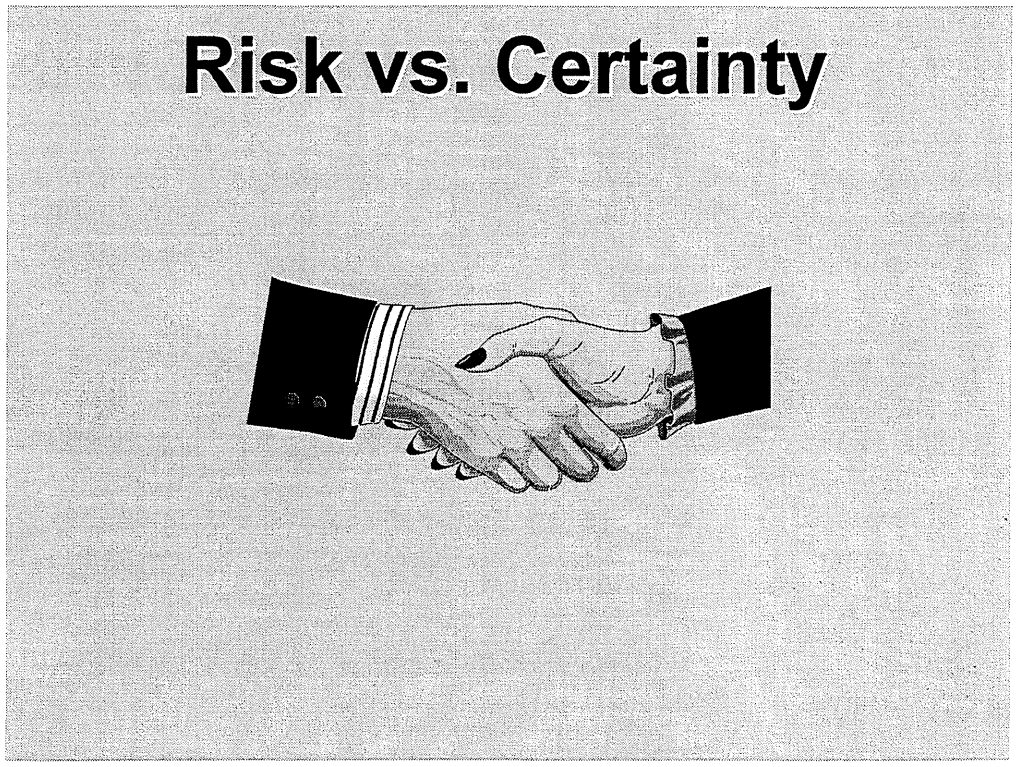
These concepts include:
- Risk vs. Certainty
- After-the-sale Costs
- Forecasting the Future



Risk vs. Certainty

Customers buy a product for what it will do for them. The buyer of a health care network or an insurance product purchases it to gain certainty that he/she will have medical coverage and care in the event of unforeseen need or disaster. These customers are buying protection from economic loss.

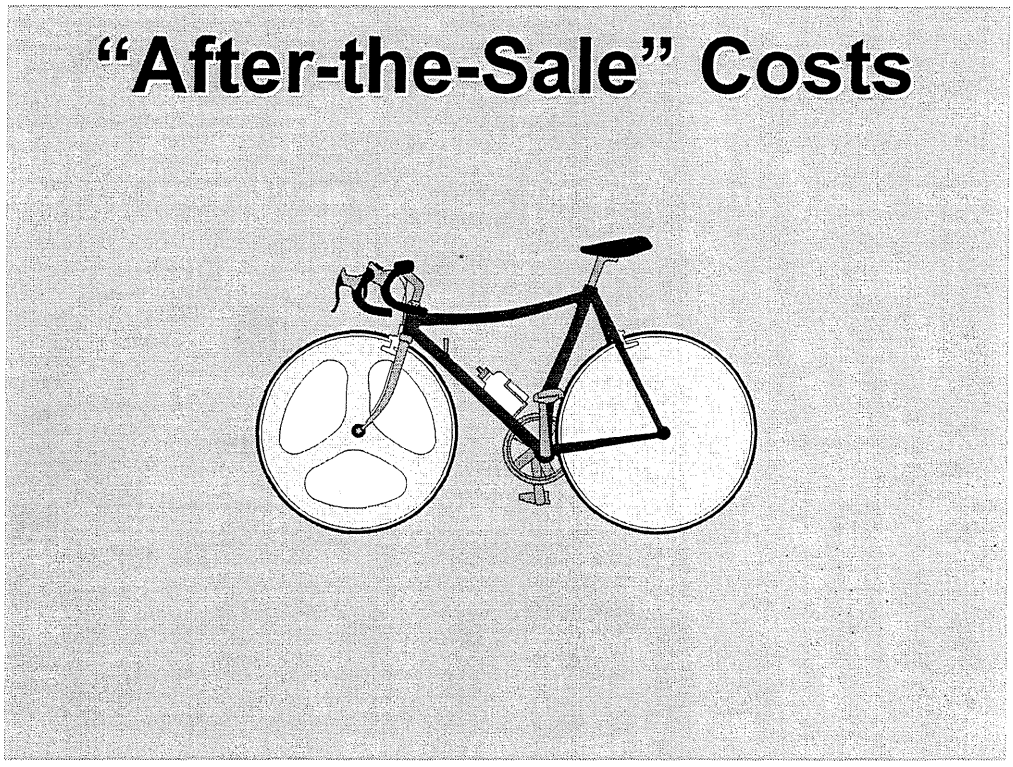
The managed care or insurance company, on the other hand, takes the risk of *possible* economic loss by guaranteeing the price of that health care coverage, regardless of what the actual costs may end up being. As specified in a ***contract***, the health care manager or insurer guarantees care and coverage over a certain period of time in return for the customer's payment of a predetermined fixed price, or ***premium.*** The price that a customer must pay for such protection is based on how much risk the company will assume. Risk is carefully calculated by the health care management or insurance company before premium or contract prices are set.



Risk vs. Certainty *(continued)*

Naturally, an insurer tries to minimize the degree of insurable risk as much as possible. Within its ability to calculate, the company is able to foresee the normal costs and estimate catastrophic losses so that prices are adequate to cover expenses and leave something for profits. Risk management means forecasting what costs are going to be and setting the premiums or contract rates accordingly.

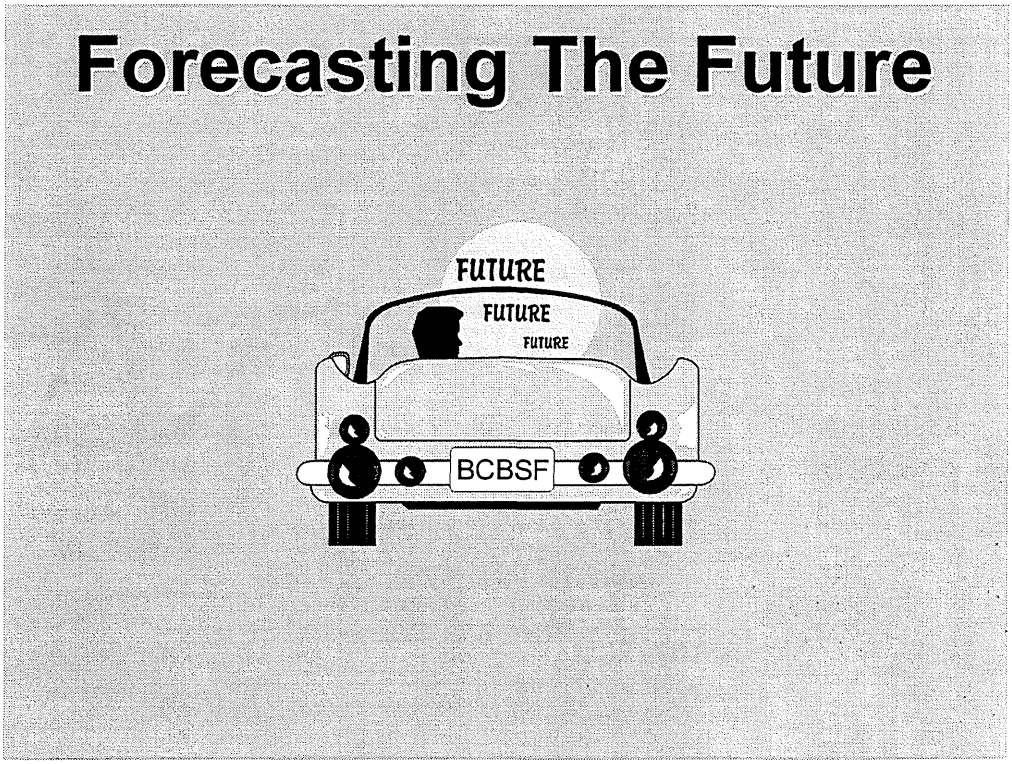
Managing costs associated with risk is of primary importance in the managed care/ health insurance business. BCBSF's managed care programs are proving effective at controlling medical expenses. In 1994, the average premium increase for BCBSF's HMO was 2.3 percent — less than the inflation rate and far less than the average 11 percent increase for traditional insurance coverage



"After-the-Sale" Costs

Pricing a product in the care management and health insurance industry is different than in others. In most industries, the costs of producing a product can be calculated before the sale. Bicycle manufacturers, for example, know all the costs that go into producing a bicycle, such as the price of raw materials, research, marketing and production. Companies like bicycle manufacturers also can know, almost on a day-to-day basis, when the costs for raw materials go up; then, prices of their products can be adjusted accordingly. As we saw in the "Formula for Success," the price of a product must be based on what it costs to produce that product, plus an adequate amount for profit.

Managed care companies and insurers do not know what the actual costs for medical services will be until after the sale has been made. With traditional insurance, how much the insurer must pay out is only known for sure only when the customer begins using medical services.

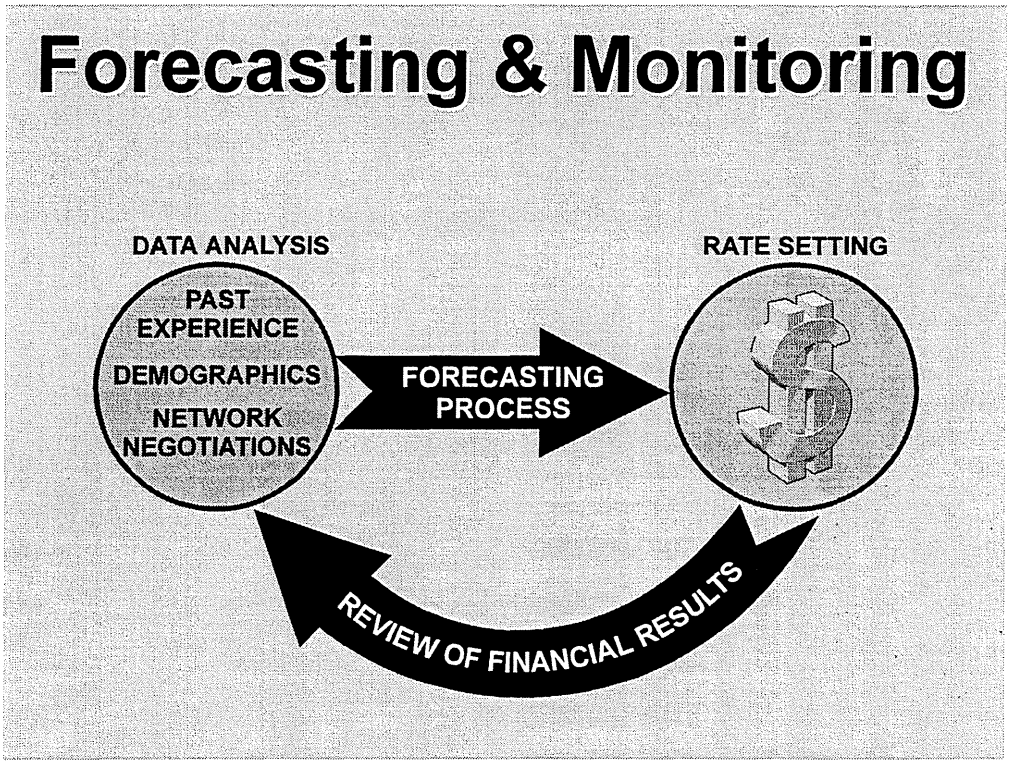


Forecasting the Future

How does a managed care company or an insurer calculate what its costs might be in the future? A company predicts what is likely to happen in the future by looking at the past. Like looking into a rearview mirror, companies analyze date from the past — medical trends, utilization, tends, claims costs, administrative costs, etc. — to determine possible costs in years ahead. From this information, the company ***forecasts*** prices for future contracts.

Historically, forecasting has resulted in rate-setting or premiums. As the business moves toward the management of care, however, forecasted costs will be translated into a care management amount. BCBSF's goal is to set care management and premium prices to be as competitive as possible, while still meeting profit objectives.

Factors and events that influence cost and utilization can cause ups and downs in the prices of health care. When high costs force premium prices up, caution must be taken to ensure the retention of market share.



Forecasting the Future *(continued)*

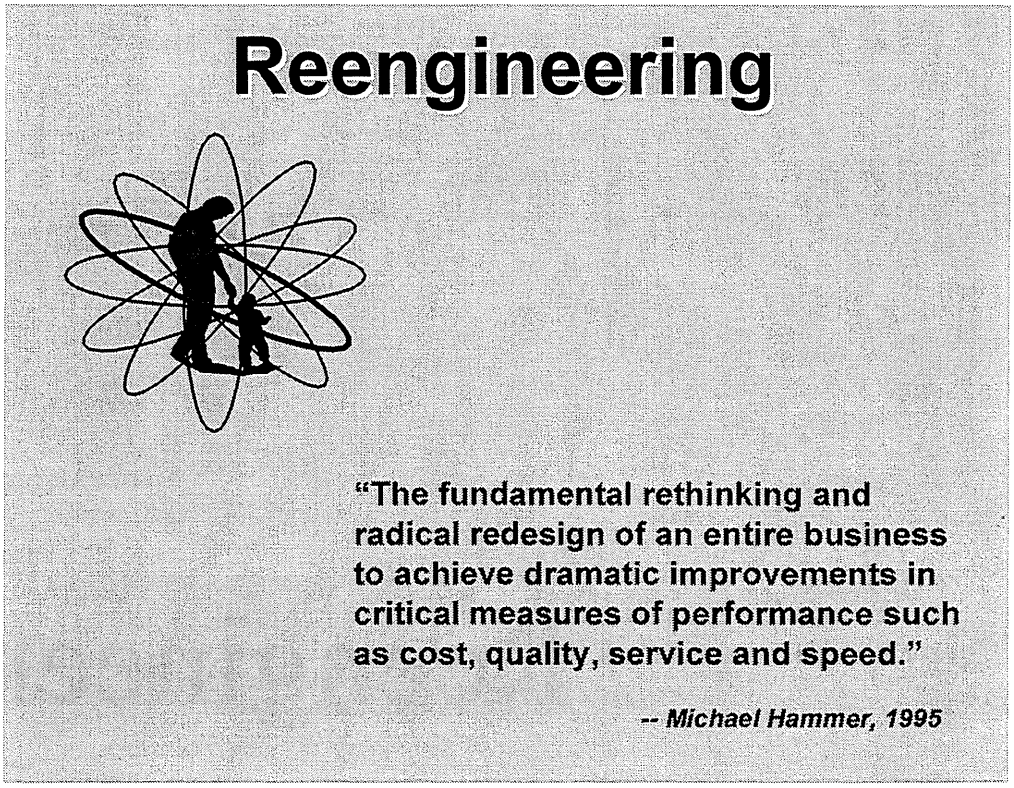
It is impossible to forecast future health care costs with 100 percent accuracy because nobody can predict the future. Some error is expected. When this happens, perspective is gained about what went wrong and corrections are made in future forecasts.

At BCBSF, routine review of financial results is an important element of managing the business. Weekly, the forecast of a month's financial results is compared against actual results. Variances are identified and evaluated. If prices must be increased because past data indicates excessive costs for the amount of revenue received, then an increase may go into effect at the renewal time for that contract.

Quarterly, each market segment's performance is re-forecast based on updated information and analysis of year-to-date results. Annual plans may be modified or adjusted based on this quarterly forecast.

Notes

Reengineering



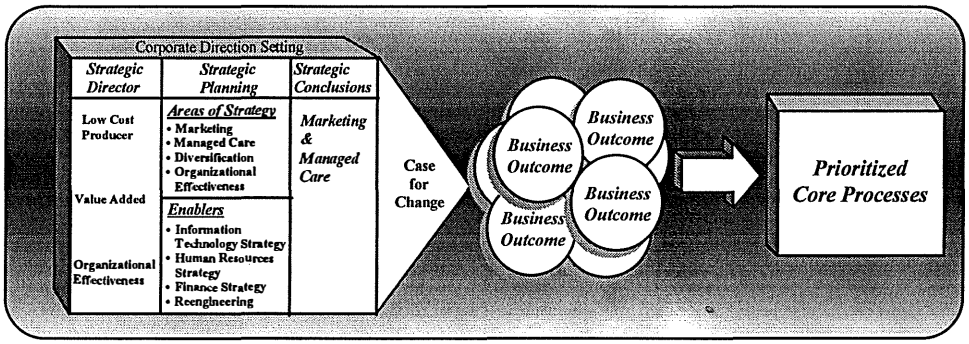
Reengineering

Given the demands of an industry undergoing enormous changes, BCBSF must become more flexible, more responsive and more customer-focused in order to maintain our competitive advantage.

In January 1994, the Executive Staff chose reengineering as the primary tool BCBSF will use to make radical and fundamental changes to the way we do business – so we stay in business.

1995 Direction Setting

Business Transformation Planning & Corporate Direction Setting



Reengineering *(continued)*

Every year, the senior executives of BCBSF engage in a process called "strategic management" to re-examine the long-term direction for the corporation.

Because our environment is changing so rapidly, we need to make some big changes in the way we do business if we want to stay competitive.

In 1995, reengineering was added to the Corporate Direction as an *enabling* strategy that supports our driving strategies of marketing and managed care, which, in turn, support our corporate direction.

Case For Change

We must significantly change and achieve dramatic improvement in the way we do business in order to attain our corporate direction of low cost producer.

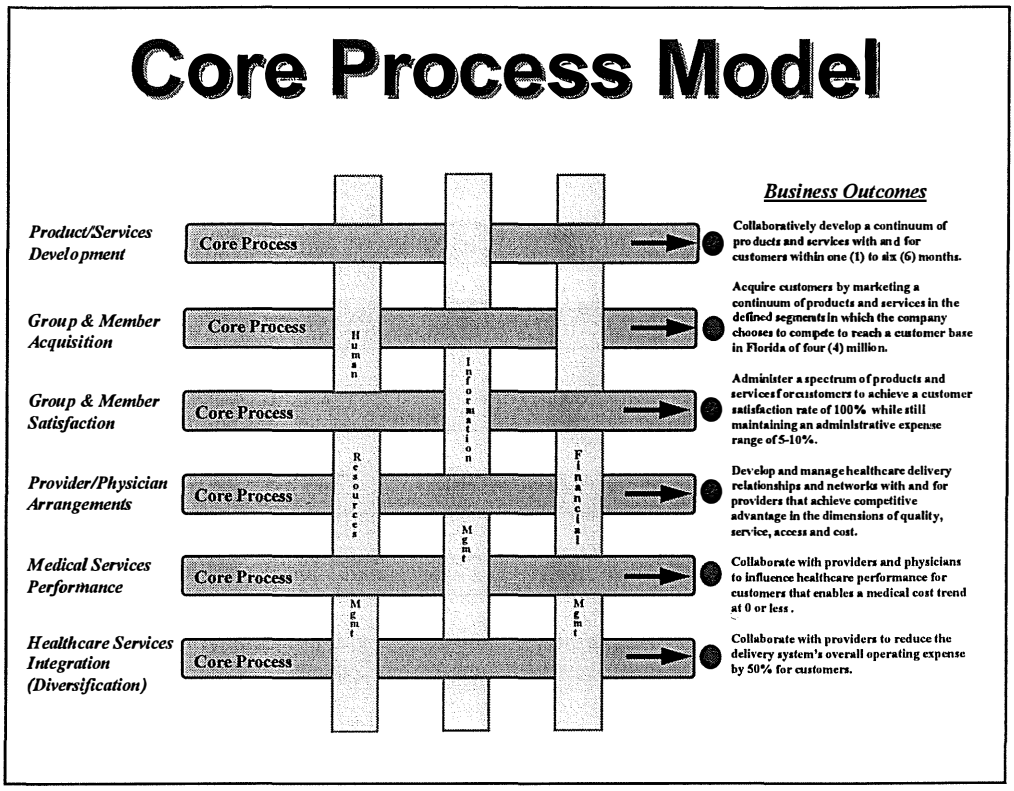
Category	Current	Future
Membership (Florida Market)	1.9 million customers 15.1% Market Penetration	4.0 million customers 25% Market Penetration 92% Retention Rate
Dimensions of Competition	Cost (managed care) Access (network) Service (total) Quality (network and price use)	Total value/price (cost vs. total value) Access (customer segment defined) Service (total experience/encounter mngmt.) Quality/outcomes/value (accountable for entire service experience)
Organizational Effectiveness	Command/Control	Participative/adaptive/continuous learning
Administrative expenses (based on current environment)	15% plus	5 - 10%
Medical cost increases	Consistent with CPI	0 or less
Delivery System / Provider Relations	Control Cost: • Contracts • Discounts • State-wide	Collaborative, win-win relationships with selected providers • Secure access/build influence with PCPs • Selective relationships with hospitals • Build market position
Product Development and Roll-out	Internal: • Reactive • 18-plus months	Collaborative (BCBSF, members, Providers): • Proactive / Innovative • 1 to 6 months
Diversification	• No consistent transferable model • Not prepared for business acquisition & integration with corporate processes • Limited within Florida	• Model office for managed care • Acquired and effectively integrating new businesses in the corporate environment • Outside of Florida • Acquisition opportunities
Competition	• Companies evolving to Managed Care	• New entrants include mature HMOs
Return on Equity	15%	15+% with a year-to-year range of 10-20%

Reengineering *(continued)*

Experts predict a consolidation in the health care industry. Afterwards, they predict there will only be three or four large competitors serving each market with a multitude of smaller companies competing for niches. To survive. . . BCBSF will need about 25 percent of the market.

BCBSF currently has almost two million customers in Florida. To double that number, we have to develop new products, improve our delivery systems, attract new customers and keep more of our current customers.

These, and other changes, are described in the corporate Case For Change.



Reengineering *(continued)*

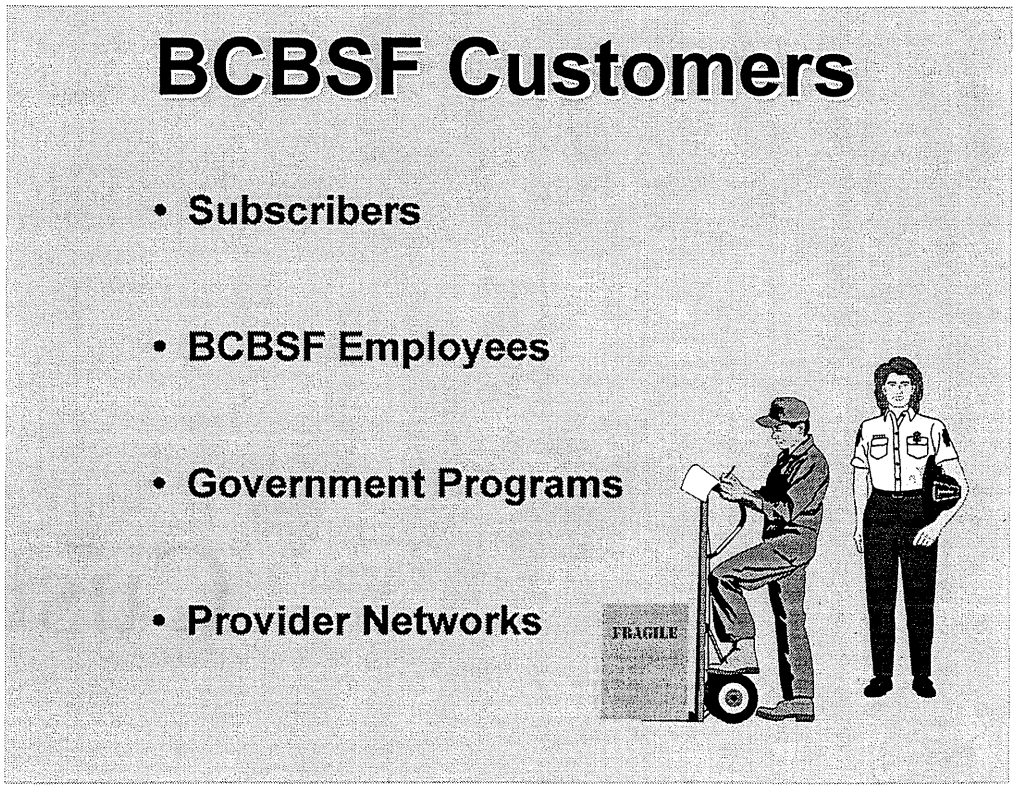
When designing a company of the future, it often helps to step back, look at the big picture, and ask questions like: "What does it take to win?"

The Executive Team asked that, and other questions, and identified six business outcomes that are considered key to winning. A business outcome is an organization's consistent ability to do something of value for its stakeholders, providing competitive advantage for the company. Each outcome must be process-anchored, customer-focused, and measureable.

These six outcomes will provide guidance to everyone involved in the reengineering effort.

Notes

Customers



BCBSF's Customers

The current market for BCBSF is essentially represented by the state boundaries of Florida. There are approximately 14.1 million people who live in Florida. Only California, Texas and New York have larger populations.

BCBSF currently has approximately 18 percent of the market share — more than double its nearest competitor.

BCBSF customers can be placed into categories:
- subscribers (individual and employer groups)
- government programs
- BCBSF employees
- provider network

Major Employer Customers

• Federal Employees Program	127,000+
• Publix Supermarkets	28,500+
• Metro Dade Co. Public Health Trust	23,000+
• Florida Power & Light Group, Inc.	10,000+
• Florida Farm Bureau	8,000+
• Florida Power Corporation	5,000+
• Marion County School Board	4,000+

BCBSF's Customers *(continued)*

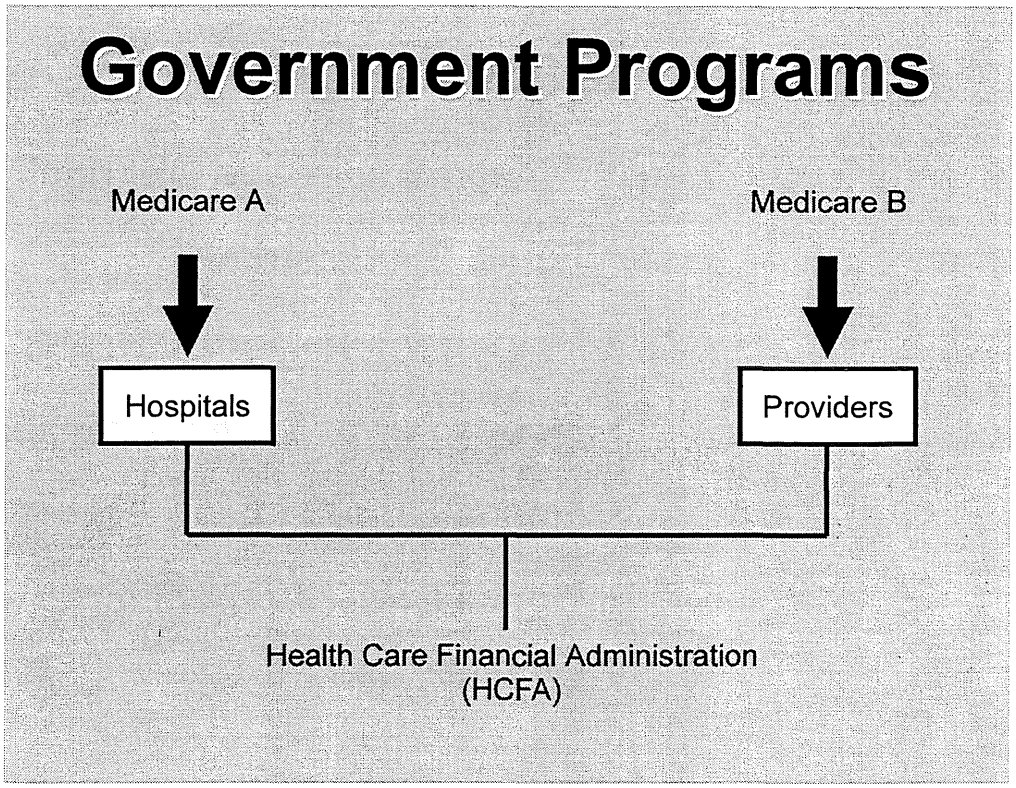
In the late 1930s and early 1940s, employers began buying group insurance for large groups of workers. The 1950s marked an era of growth and expansion of benefits, including certain allied benefits such as vision care and major medical.

Since then, health insurance has become an important part of total compensation for two reasons:

- an employer typically spends over $1,500 per employee
- it is a tax-free form of compensation, giving it greater value to both the employee and the employer

BCBSF serves both the private and public sectors:

largest public employer – Federal Employees Program
largest private employer – Publix Supermarkets

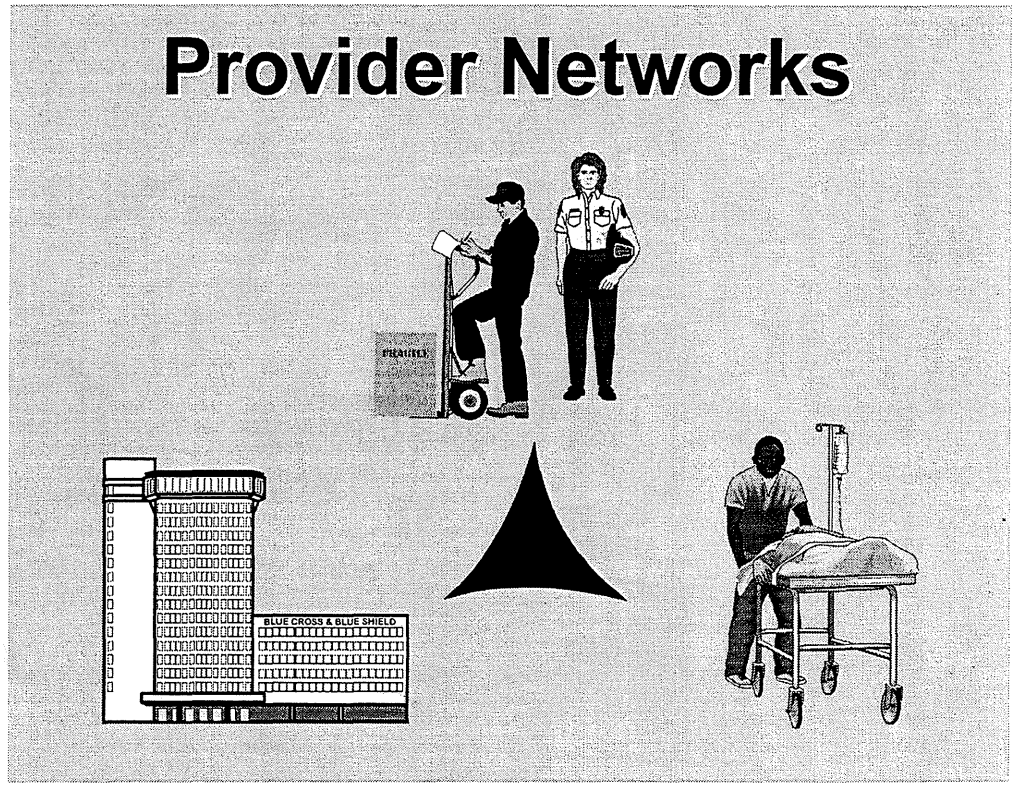


BCBSF's Customers *(continued)*

Medicare was created in 1966 as a federal insurance program for persons 65 years or older and certain disabled individuals. The program is administered by the Health Care Financing Administration (HCFA) based in Baltimore. HCFA is part of the federal Health and Human Services department.

BCBSF provides administrative services for both parts of the Medicare program and does not take on any medical risks.

Medicare A – the hospital insurance program
Medicare B – the medical insurance program



BCBSF's Customers *(continued)*

BCBSF places a high value on its relationship with hospitals and providers.

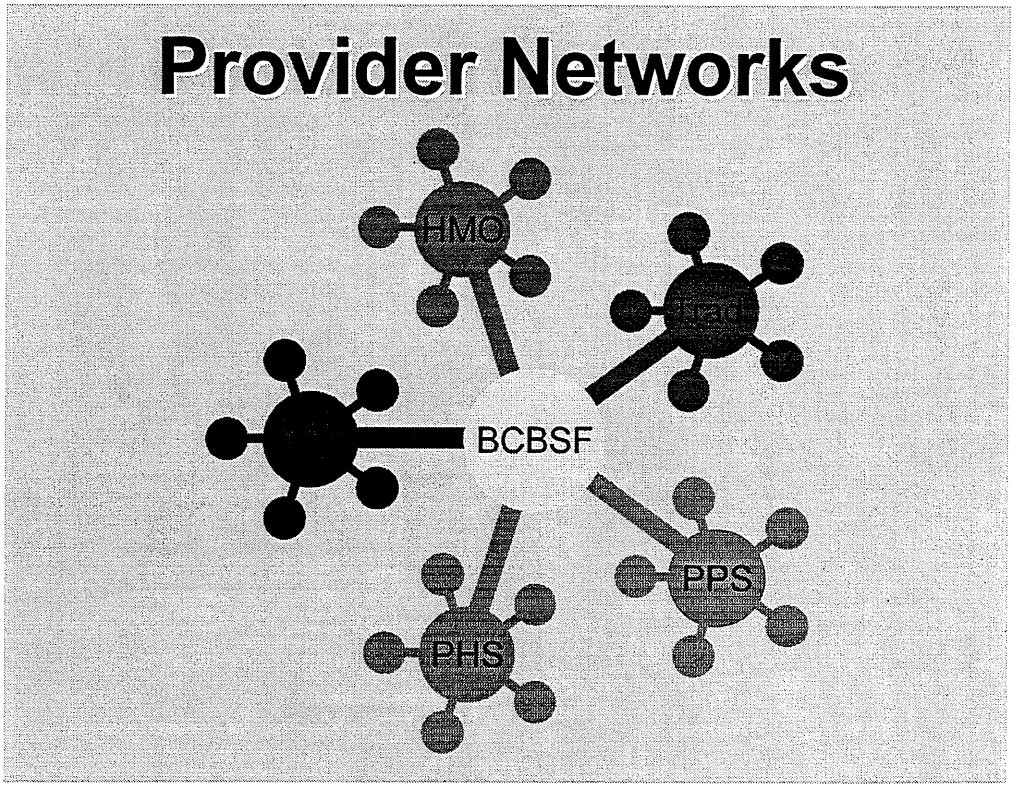
Excellent service to the provider means:
- adequate education on new/existing products and programs
- timely and accurate payment of claims
- accurate explanation of benefits (EOB) statements
- friendly and professional customer service

Provider networks provide benefits to everyone involved:

BCBSF
- receives a discount from the provider
- able to manage cost and utilization with the provider
- leader in industry

Provider
- more patients
- predictable service from BCBSF
- reduced bad debt and administration costs

Customer
- receive service from local providers
- no balance billing



BCBSF's Customers *(continued)*

There are five networks which BCBSF works with:

Type	% of physicians	% of hospitals	Features
Traditional	71	96	• some type of discount to BCBSF's traditional customers • significant number of providers to choose from
PPO	54	60	• greater discount to BCBSF's PPO customers • providers receive referrals
HMO	26	40	• largest discount to BCBSF's HMO customers • smaller number to choose from
PHS	-	93	• compliments the PPO product • additional savings for out-of-network services
PPS	74	-	• coordinates with the PPC product • additional savings for out-of-network service

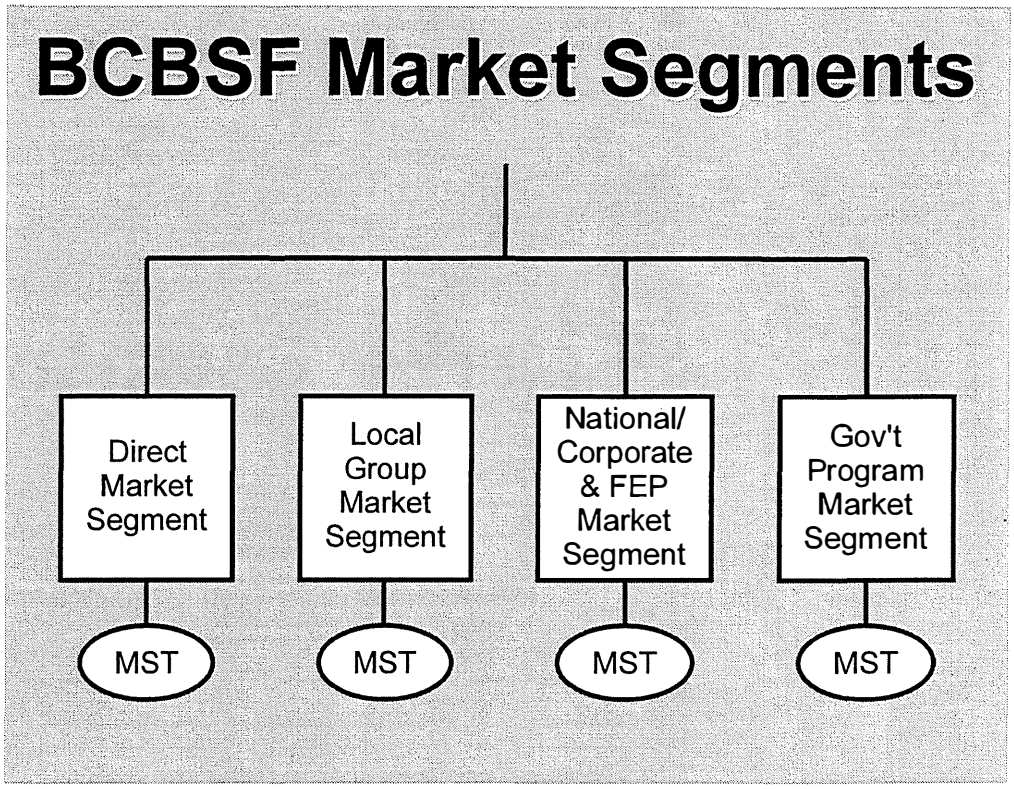
Market Segmentation

BCBSF's approach to marketing is to segment first, identify target markets, then match customer needs with products, prices, and delivery mechanisms.

BCBSF must be able to quickly develop new products to meet changing customer needs and be ready to adapt to a changing marketplace.

BCBSF uses two groups to market and sell its products and services:

- BCBSF's Regional Sales Staff
- BCBSF's Licensed General Agent Network



BCBSF's Market Segments

BCBSF maintains a customer focus by managing four market segments:

- Direct Market Segment
- Local Group Market Segment
- National/Corporate & FEP Market Segment
- Government Programs Market Segment

MST's monitor products + services for satisfaction + profitability

Market Segment Teams (MSTs) are standing, operating committees which develop strategies and business plans to meet the needs of the market segments. Each team monitors its products and services for satisfaction and profitability.

The MSTs consist of representatives from Operations, Marketing, Finance, Health Care Services, Human Resources, and the Regions.

BCBSF Market Segments

Private Business

	Direct	Local	Nat'l/Corp. & FEP
Approx. Premuim Revenue	$636 million	$967 million	$540 million
Approx. % of PBOs Enrollment	34%	36%	30%

Customers	• Over 65
	• Under 65
	  • Self-employed
	  • Supplemental coverage
	• Small groups
		• All groups (except a limited number of large/selected groups)	• Public and private employers with employees located in and out of Florida

Products	• Medicare supplements • Trad. Health Insurance • Managed Care (PPO & HMO) • Temporary Insurance	• Trad. Health Insurance • Managed Care (PPO & HMO) • Life Insurance • Accidental Death & Dismemberment • Disability	• Trad. Health Insurance • Managed Care (PPO & HMO) • Life Insurance • Accidental Death & Dismemberment • Disability

Source: Standard & Poor's, October 1995

BCBSF's Market Segments *(continued)*

All BCBSF e/s – Nat'l Corporate

BCBSF Market Segments

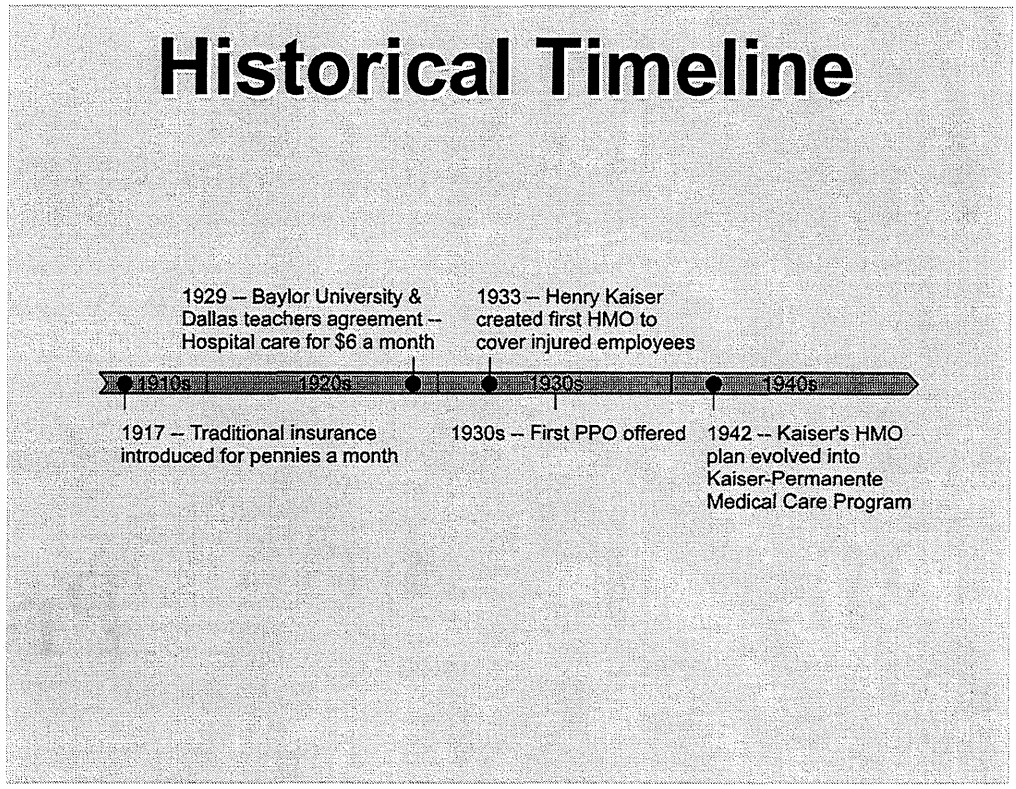
Government Programs

- Administers the Medicare Part A and Part B programs
- Serves persons 65 years and older as well as certain disabled individuals
- Paid over $7.5 billion in health care benefit payments in 1993
- Processes approximately 54 million claims a year

BCBSF's Market Segments *(continued)*

Notes

Products



Health Care Industry Timeline

For nearly 100 years, the health care industry has gone through an evolution of products that is both complex and broad in scope.

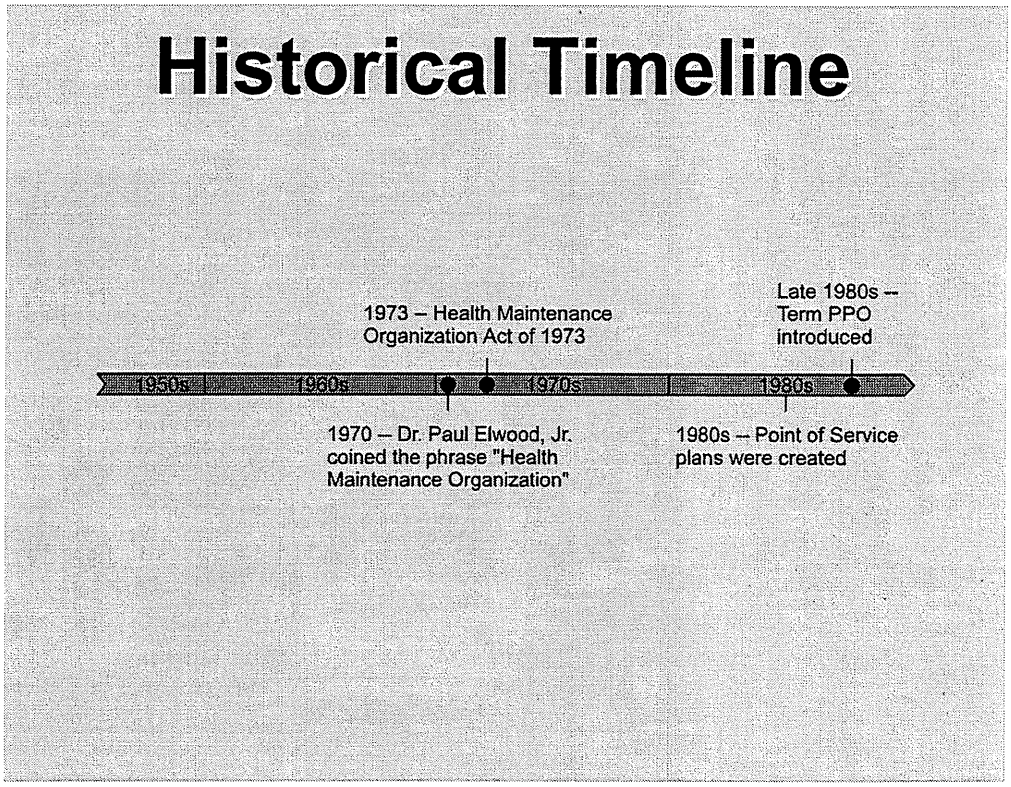
1917 — Traditional insurance is first used in Washington state where the medical needs of lumberjacks and miners are covered by their employers for pennies a month.

1929 — Agreement was reached with Baylor University Hospital and Dallas Teachers for 21 days of hospital care. Premium payments are $6.00 a month.

1930s — The first Preferred Provider Organization (PPO) where members are given financial incentives to seek medical care from providers who agreed to provide services at pre-negotiated rates.

1933 — Henry Kaiser creates the first HMO where he paid a set fee per employee to cover work-related injuries.

1942 — Kaiser's plan becomes Kaiser-Permanente Medical Care Program – the best known HMO prototype.



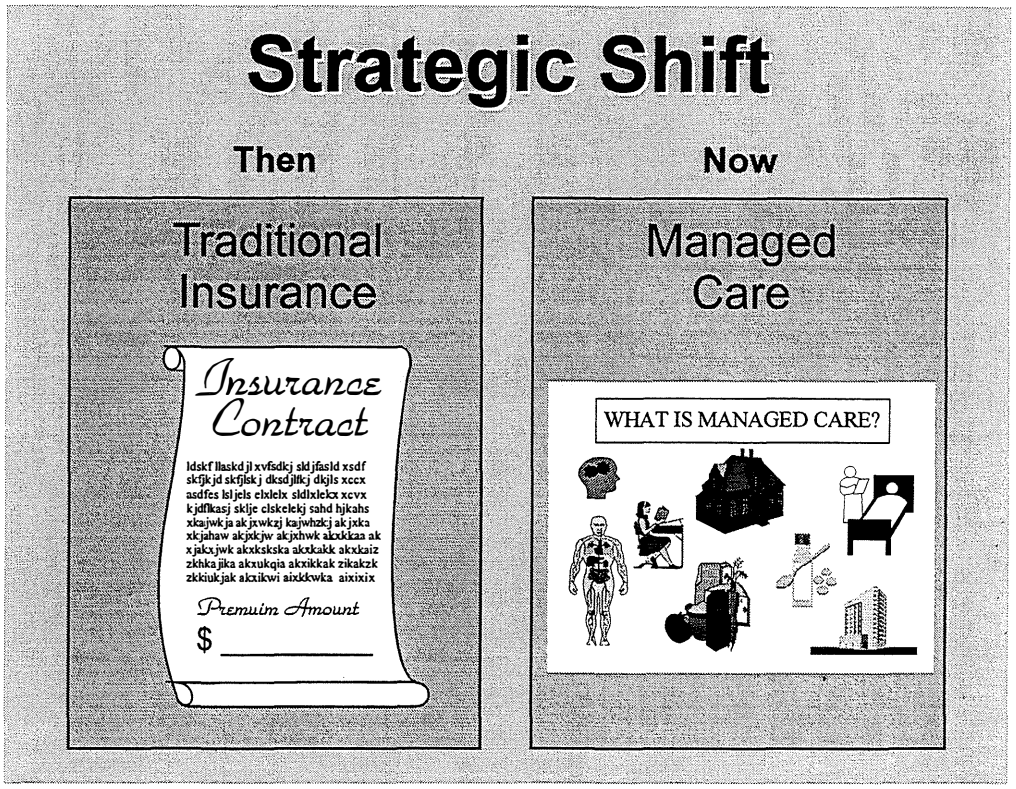
Health Care Industry Timeline *(continued)*

1970 — Dr. Paul M. Elwood, Jr., a Minneapolis doctor, coins the phrase "Health Maintenance Organization."

1973 — Health Maintenance Organization Act of 1973 – employers with 25 of more employees could be mandated to offer financially qualified HMOs as another choice for health care coverage.

1980s — Point of Service plans are created with the cost containment/managed care features of PPOs and HMOs as well as coverage for out-of-network services similar to traditional products.

Late 1980s — The term PPO is first used.



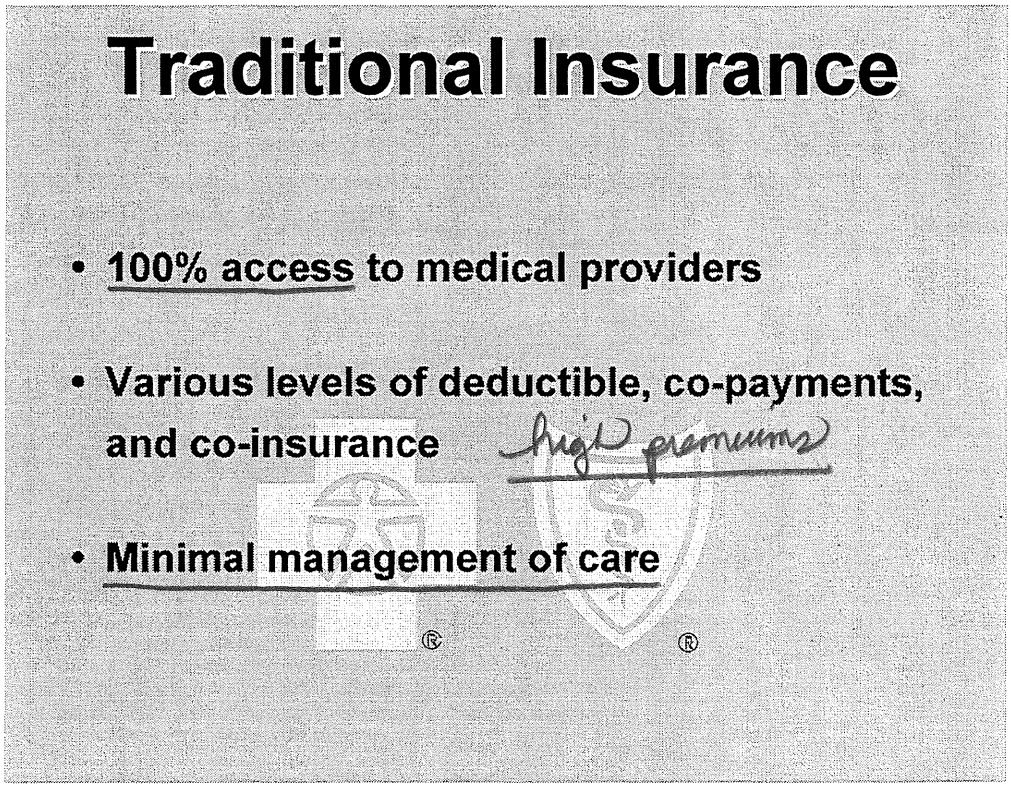
Strategic Shift to Managed Care

Cost and access have become the elements which the customer and insurer want to control.

Key players have to strategically shift their approach to care by moving from *financing* a product to *delivering* a product.

Then — traditional products are simply financing mechanisms that improved access to necessary medical care.

Now — managed care programs lower costs by channeling care to cost effective providers and settings, and making preventive care and effective management of chronic illness a priority.

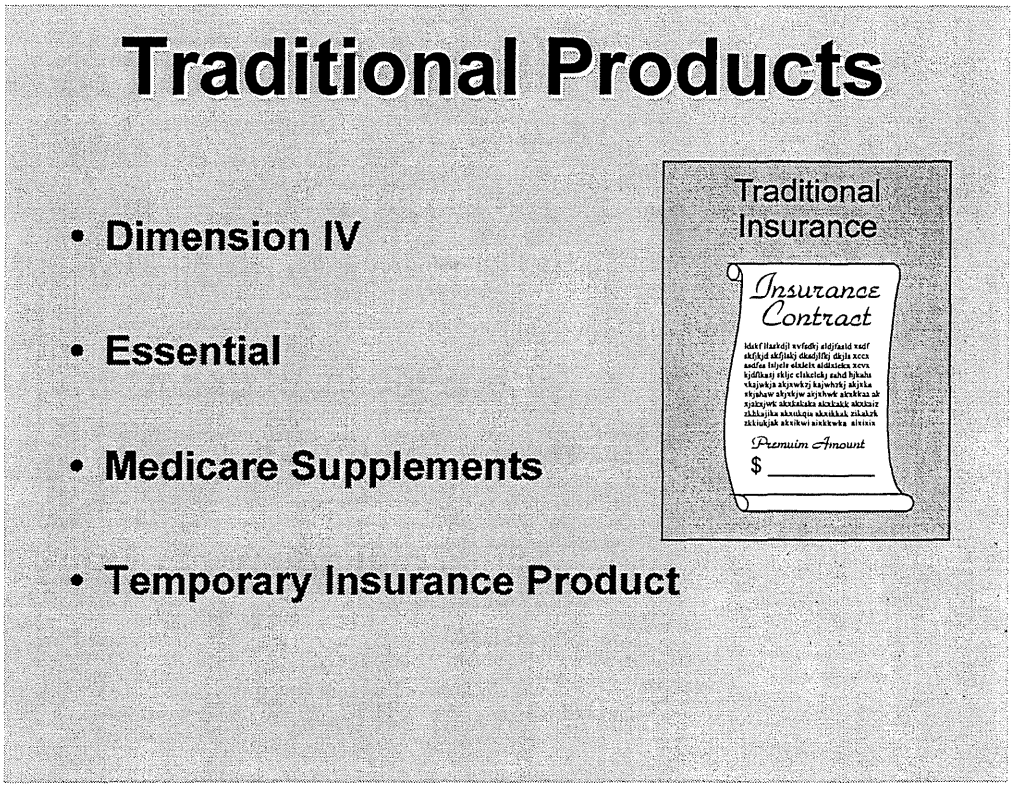


BCBSF's Products

Traditional insurance provides reimbursement for most, but not all of the patient's medical expenses. It is considered a reactive plan because the patient uses it only after illness has occurred. Preventive care services are seldom covered.

The main principle is that health care coverage is guaranteed by a binding contract to indemnify another against specified loss in return for paid premiums. Included are the premises:

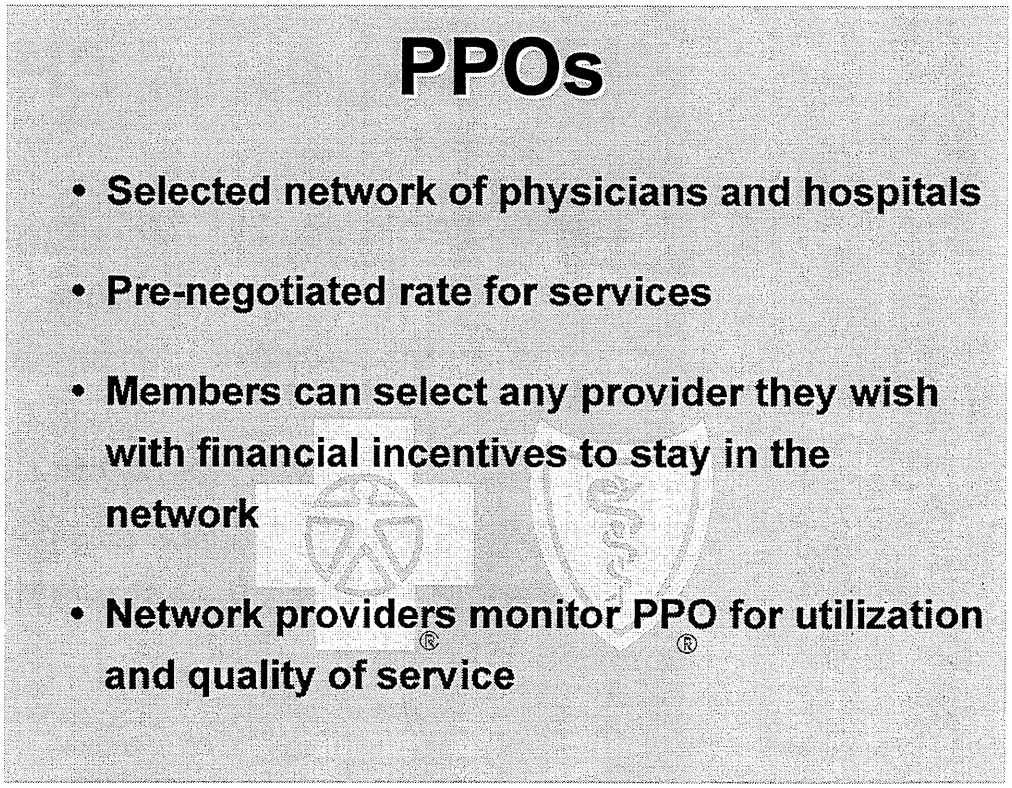
- there is 100% access to medical providers
- there are various levels of deductibles, co-payments, and co-insurance
- there is minimal management of care



BCBSF's Products *(continued)*

Products which BCBSF offers in the traditional insurance line include:

- *Dimension IV* — basic traditional insurance product
- *Essential* — hospital surgical product
- *Medicare Supplements*
- *Temporary Insurance* — coverage for 30, 60, or 90 days

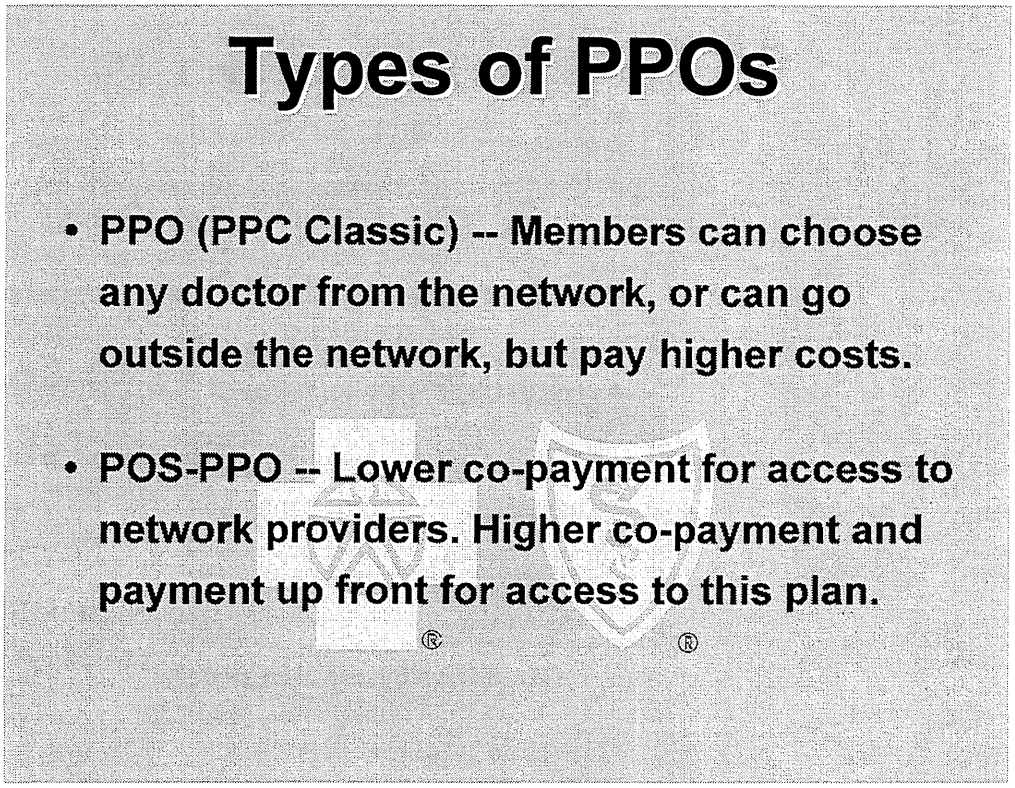


BCBSF's Products *(continued)*

The Preferred Provider Organization (PPO) product provides financial incentives for its members to seek medical care from a select group of physicians and hospitals who have agreed to provide services at pre-negotiated rates. Coverage is also provided for services received outside the network but with higher out-of-pocket expenses.

BCBSF has the largest PPO network in Florida — both in geographic coverage and total enrollment. In addition, 52 percent of BCBSF employees have chosen a PPO plan to meet their health care needs.

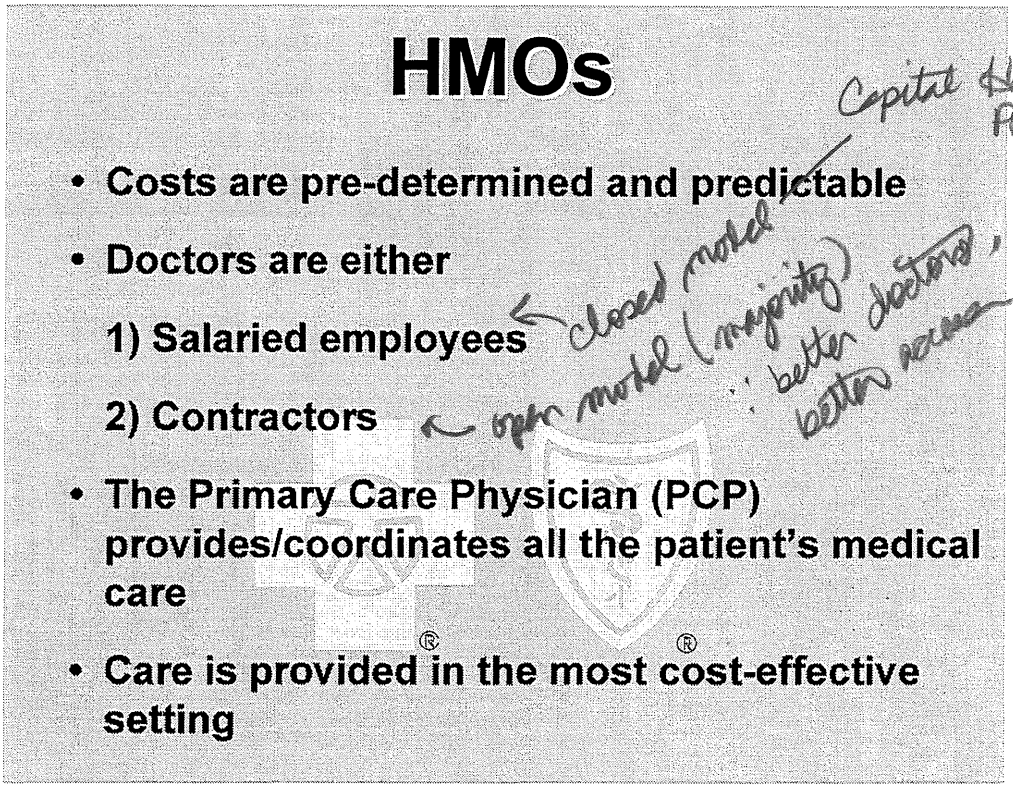
PPOs are built on four principles:
- there is a selected network of physicians and hospitals
- there is a pre-negotiated rate for services
- members can select any provider with financial incentives to stay in the network
- network providers monitor the PPO for utilization and quality of service



BCBSF's Products *(continued)*

There are two major types of PPO products:

Type	BCBSF Product
PPO (PPC Classic)	PPO Preferred Patient Care II
POS-PPO	Preferred Patient Care (PPC)



BCBSF's Products *(continued)*

The Health Maintenance Organization (HMO) is a departure from traditional insurance in that the HMO integrated providers with the payment system to provide health care services directly to the members for a pre-determined and fixed periodic payment.

The HMO concept is built on preventive care, which reduces the need for acute medical services (like hospitalization) and this ultimately manages the cost.

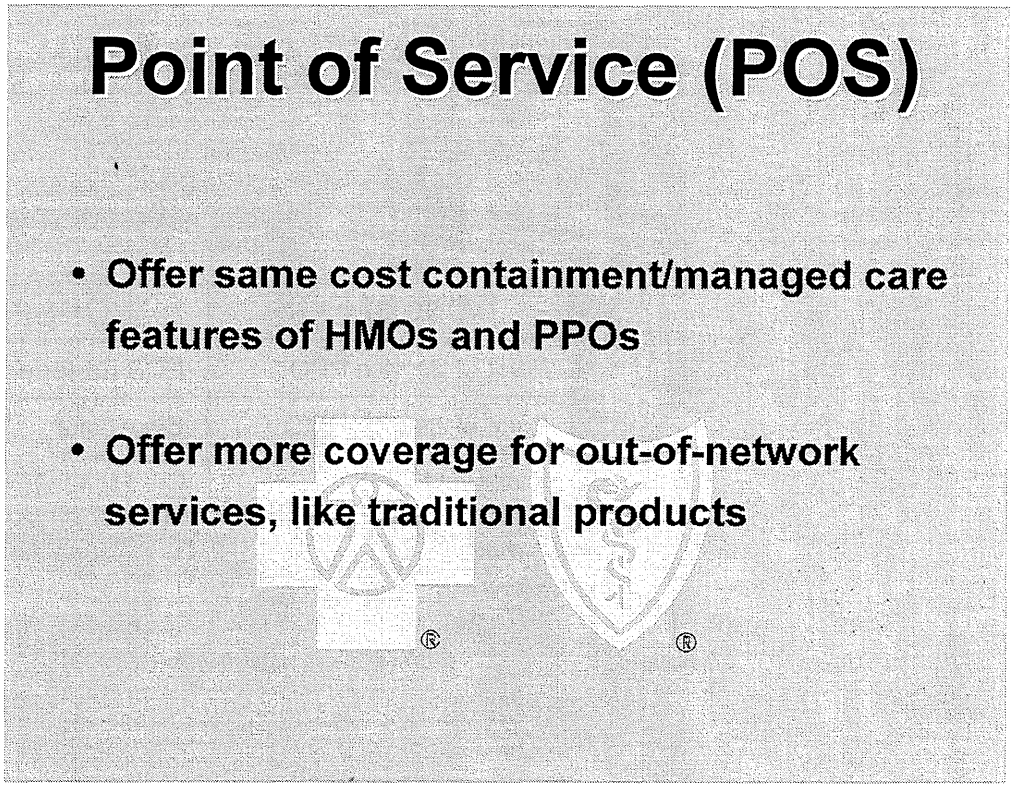
The Health Maintenace Organization Act of 1973 helped with the growth of HMOs. In 1984, two percent of BCBSF's customers were enrolled in HMO plans. At the end of 1994, 22.8 percent of these customers were enrolled in an HMO.

The HMO concept is built on four principles:
- costs are pre-determined and predictable
- doctors are either
  - salaried employees
  - contractors
- the PCP provides/coordinates all the patient's medical care
- care is provided in the most cost effective setting

BCBSF's Products *(continued)*

There are various types of HMOs:

Type	Description	BCBSF Product
POS HMO	Provides customers with the flexibility of receiving HMO benefits, if they use the network, and Traditional benefits if they go outside the network.	*Elect Care*
HMO: IPA/ Open Ended	HMO contracts directly with physicians who are compensated under a modified fee-for-service basis.	*Health Options* *Medicare and More*
HMO: Group Model	HMO contracts with one or more independent physician medical groups. The medical group is baid on a fixed rate per member.	*Health Options*
HMO: Staff Model	Closed model HMO where members choose a doctor from a staff of physicians who are members of a medical group or salaried HMO employees.	*Capital Health Plan* (Tallahassee, FL)

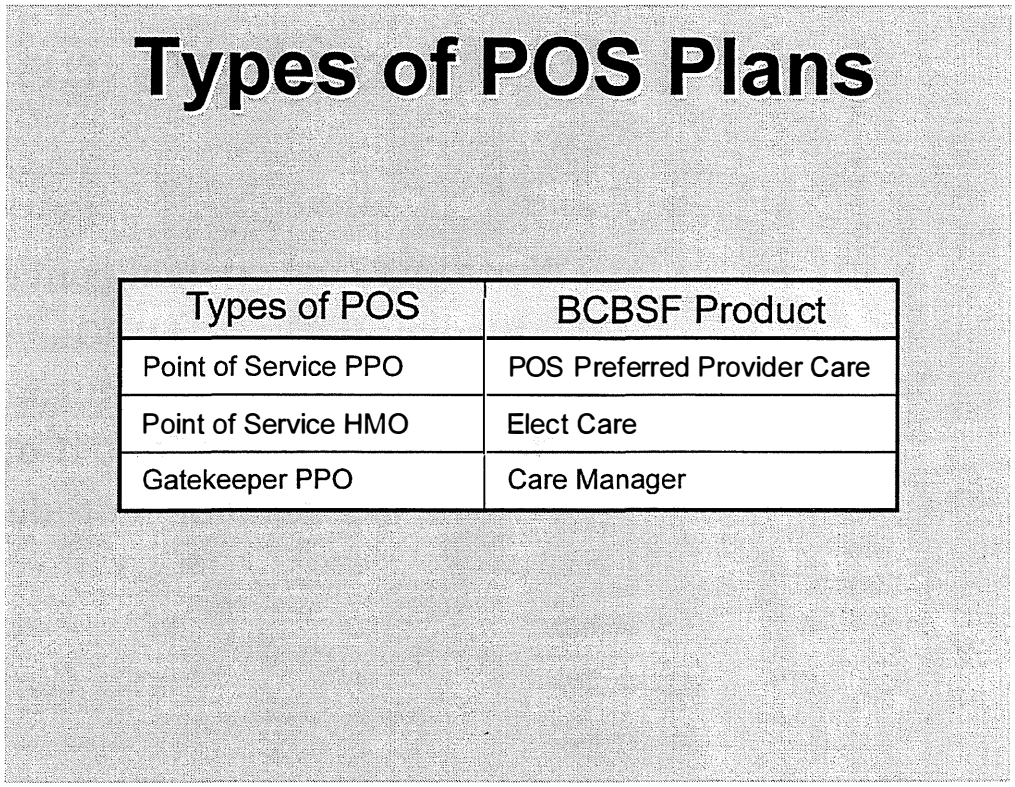


BCBSF's Products *(continued)*

Point of Service (POS) plans are a hybrid of an HMO or PPO plan and a Traditional plan. POS plans offer cost containment and managed care features of managed products as well as more coverage for out-of-network services like Traditional insurance.

POS plans allow members flexibility to make a choice of which benefit level to receive at the time of service.

elect care
(for Publix, initially)



BCBSF's Products *(continued)*

There are generally three types of Point of Service (POS) plans:

Type	BCBSF Product
Point of Service PPO	*POS Preferred Provider Care*
Point of Service HMO	*ElectCare*
Gatekeeper PPO	*Care Manager*

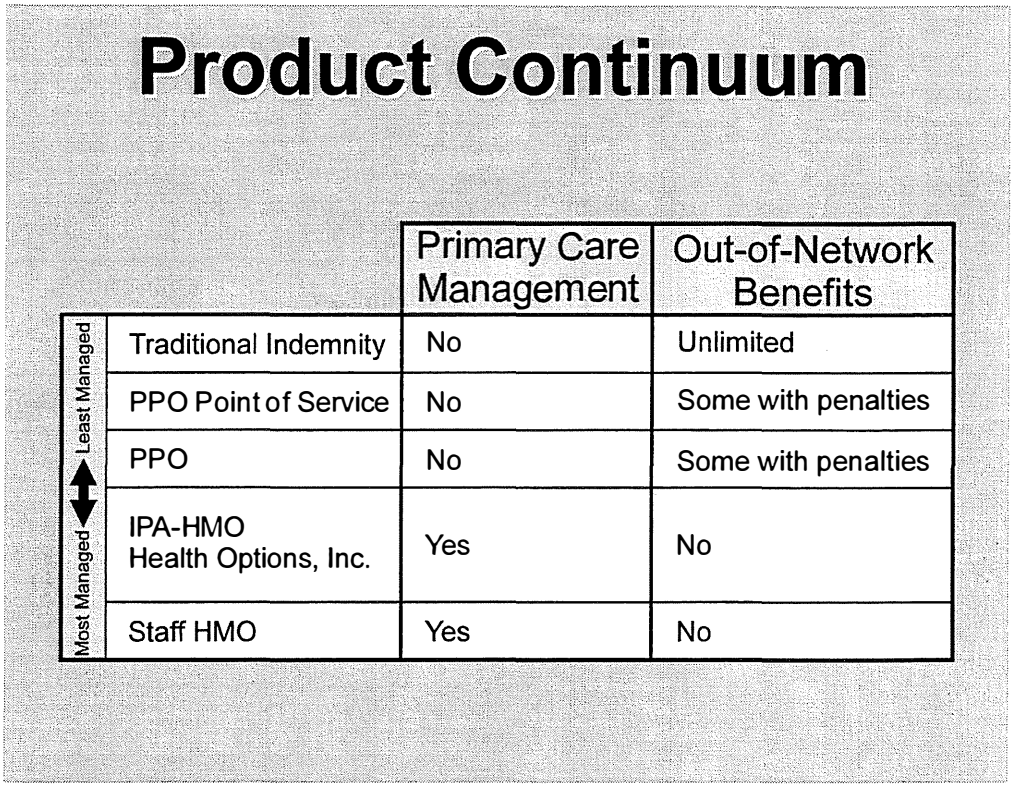
Specialty Products

Category	Product
Optional Health Care Packages	Multi-Option
	Dual-Option
Companion Products	Dental Assistance Plan (DAP)
	BlueScript
	Healthtrac
Life Insurance	Florida Combined Life (FCL)

BCBSF's Products *(continued)*

In addition to the major product lines, BCBSF offers specialty products and product combinations that more specifically meet the needs of its customers.

Category	Product	Description
Optional Health Care Packages	Multi Option Dual Option	Allows subscribers to individually choose among products (e.g. HMO, PPO, or Traditional) in a cafeteria-style benefits package.
Companion Products	Dental Assistance Plan (DAP)	A dental PPO available with all BCBSF products.
	BlueScript	A prescription drug program available with the PPC and Traditional products.
	Healthtrac	A wellness program that includes health assessment and educational programs that encourages healthy lifestyles and preventive care.
Life Insurance	Florida Combined Life (FCL)	A subsidiary of BCBSF which offers a full array of group life insurance products.

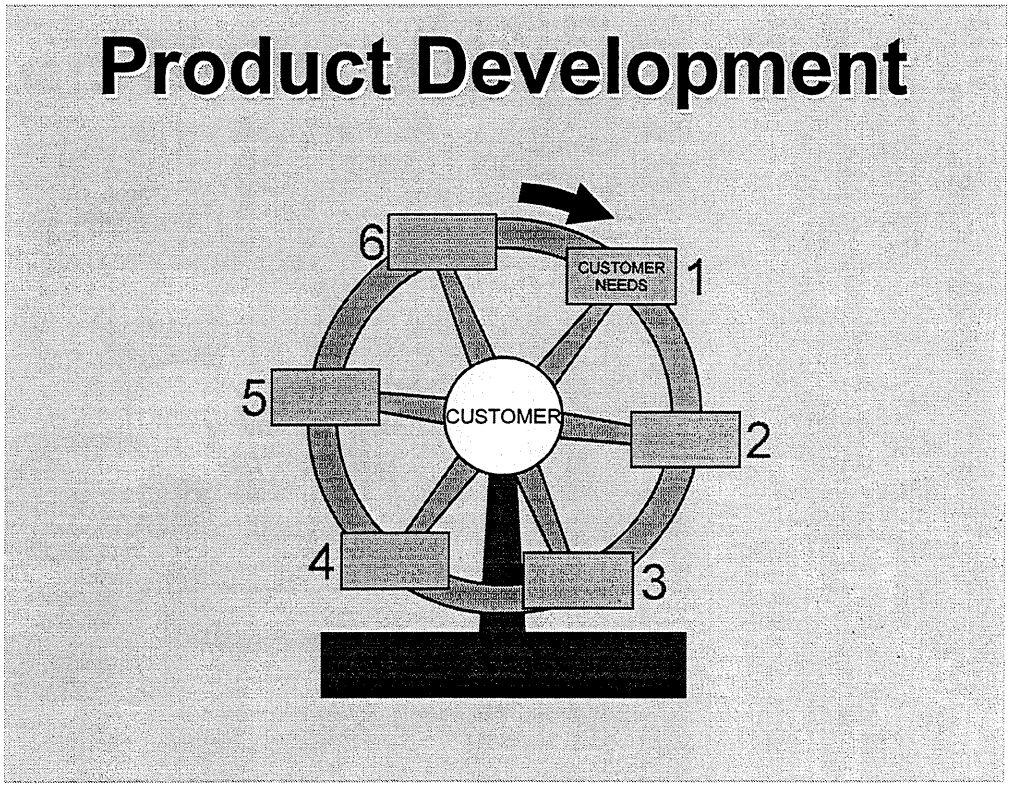


BCBSF Product Continuum

BCBSF's product continuum runs the spectrum of traditional products (where the patient pays up front, files claims for reimbursement, and has 100% choice of providers) to managed care products (where the focus is on controlling costs, access and quality; the patient pays little or no amount up front, does not file claims, and has limited choice in providers).

The product continuum includes:

Product	Examples
Traditional	*Dimension IV*
	Essential
	Medicare Supplements
Point of Service – PPO	*Preferred Patient Care (PPC)*
PPO	*PPO Preferred Patient Care II*
POS HMO	*ElectCare*
HMO-IPA	*Health Options*
	Medicare and More
Staff HMO	*Capital Health Plan* (in Tallahassee)

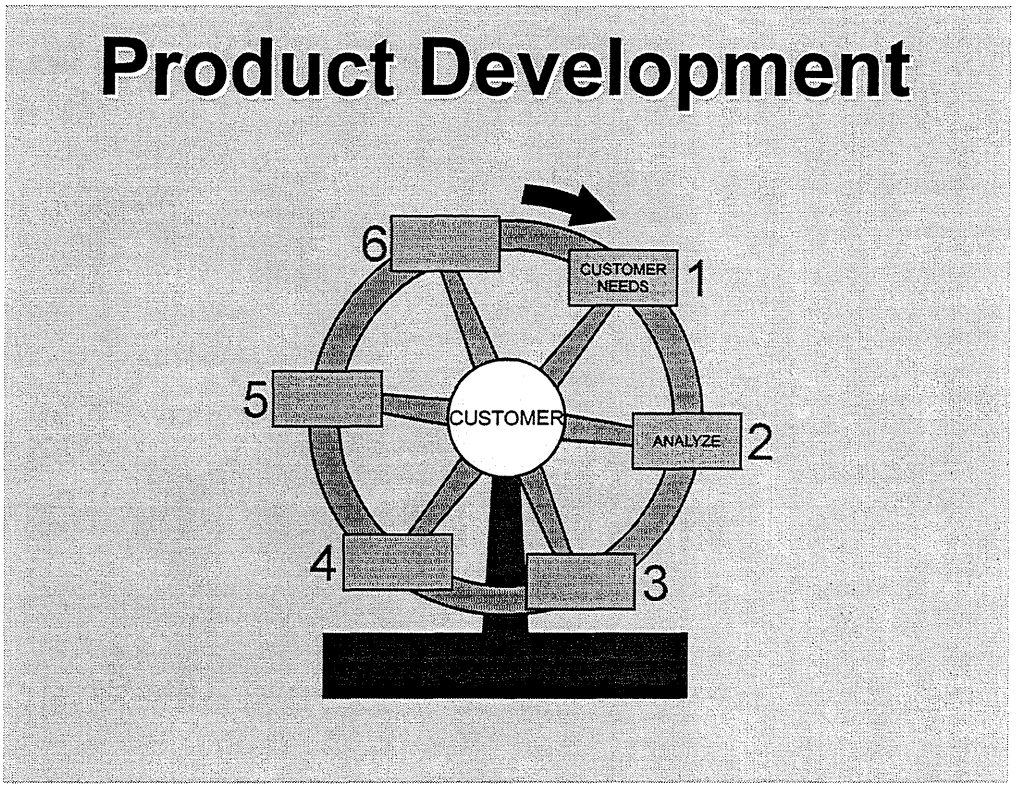


Product Development Life Cycle

There are six steps in the development life cycle of every product.

Anticipating what customers need is the first step in product design. Influencing a customer's need are the four dimensions of competition:

- Cost
- Access/Choice
- Service
- Quality

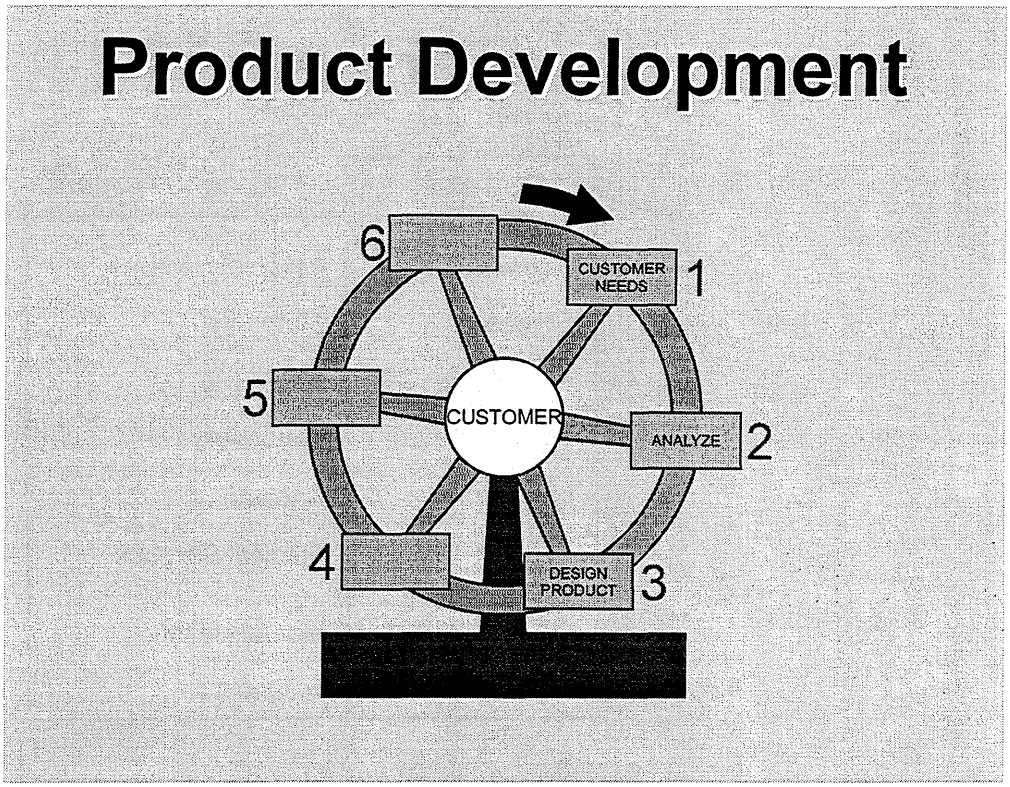


Product Development Life Cycle *(continued)*

Once the needs of the consumer are identified, BCBSF then analyzes the products that are already in place.

Generally, one of three decisions could be made at this point:

- use existing product(s)
- modify existing product(s)
- create new products(s)



Product Development Life Cycle *(continued)*

When the decision is to create a new product, the end result of step 3, the design phase, is a legal contract. The legal contract guarantees the cost of the product for a specific period of time.

There are three vital elements for this contract:
- benefit design
- networks
- provider payment arrangments (reimbursement)

Scope of Benefits

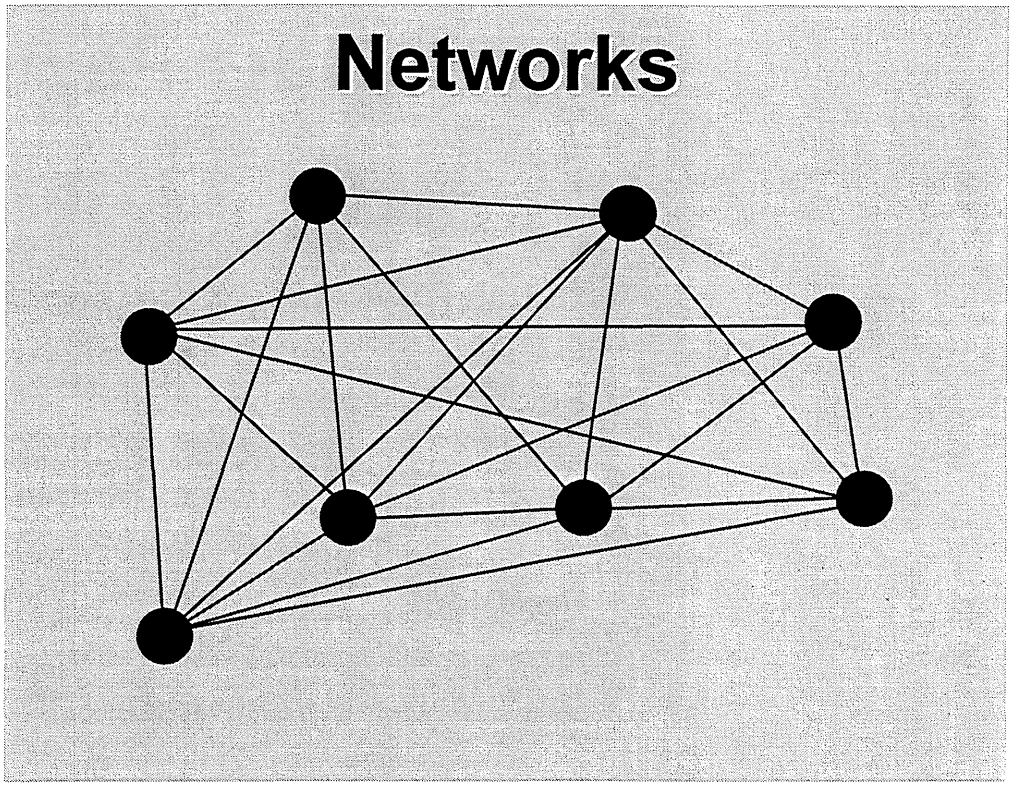
Hospital	Medical/Surgical	Ancillary
Inpatient		
Room/Board	Surgical Services	Nurses
Surgery	Maternity	Dental Services
Anesthesia	Radiology	Durable Medical
Radiology	Laboratory	Equipment (DME)
Laboratory	Anesthesia	Therapy
Supplies	Medical Services	
Outpatient		
Diagnostic Tests	Mental Health	
Therapy	Diagnostic	

Product Development Life Cycle *(continued)*

When designing the benefits of a product, there are generally two questions which need to be answered:

What is the scope of benefits that the customer needs, or what services will actually be covered?

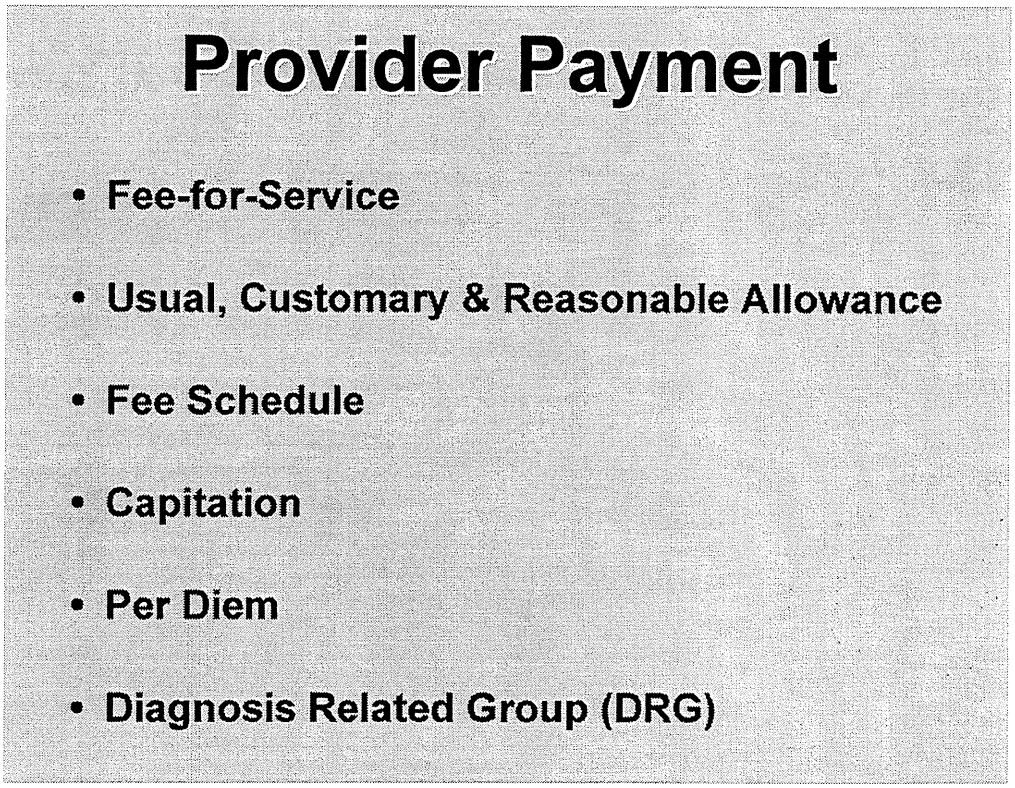
What should the extent of coverage, or limitation, on each benefit be?



Product Development Life Cycle *(continued)*

A major feature of a health care product is the array of providers who will actually deliver the care.

A ***network*** is a group of providers — doctors, hospitals, and other medical professionals — who contract with BCBSF to offer quality health care at pre-negotiated rates.

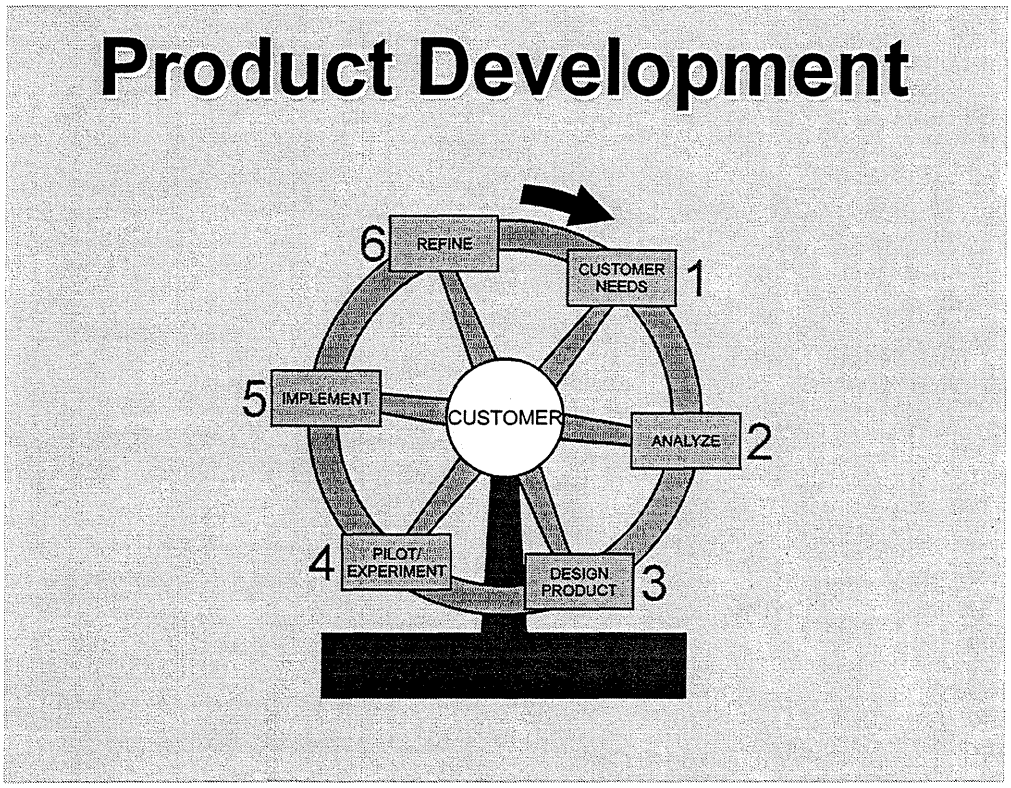


Product Development Life Cycle *(continued)*

Another critical question during the design phase is: *What provider payment arrangement(s) will be part of the product?*

Payments to providers differ according to whether or not the physician and/or hospital is participating or not participating with BCBSF.

DRG - Pay for disease related procedures and
individually, to pay for each procedure
individually.

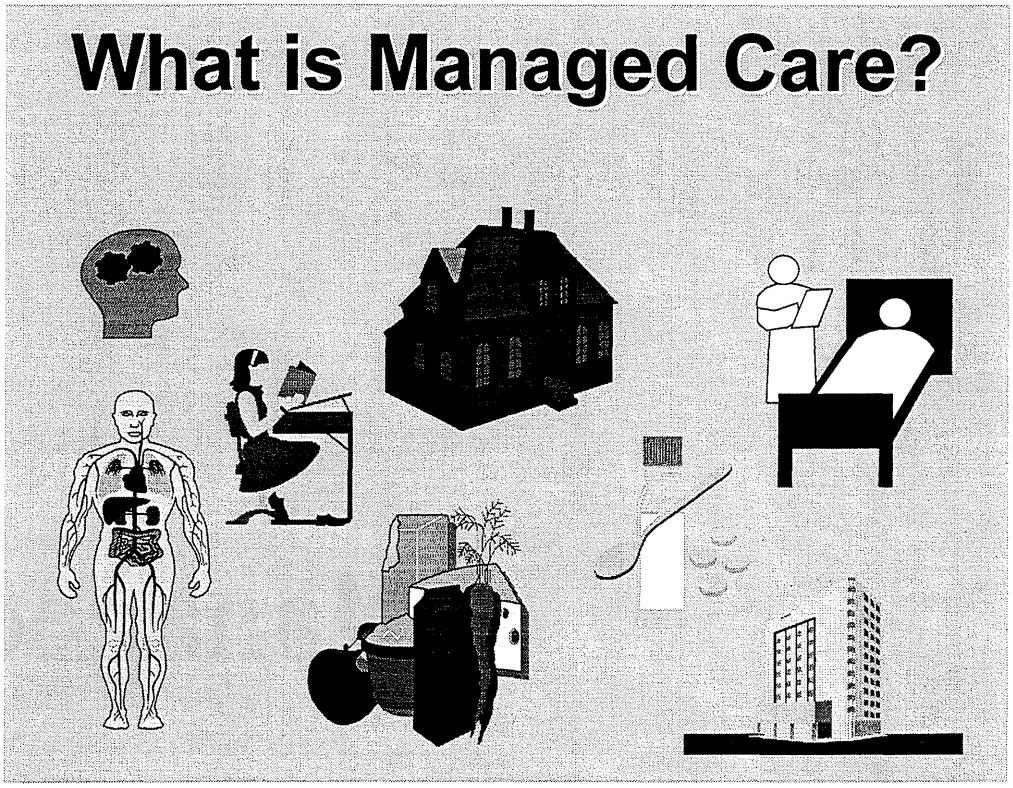


Product Development Life Cycle *(continued)*

The last three steps are to pilot the product in an experimental way, implement it, then continue to monitor the product and refine as needed.

Notes

Managed Care

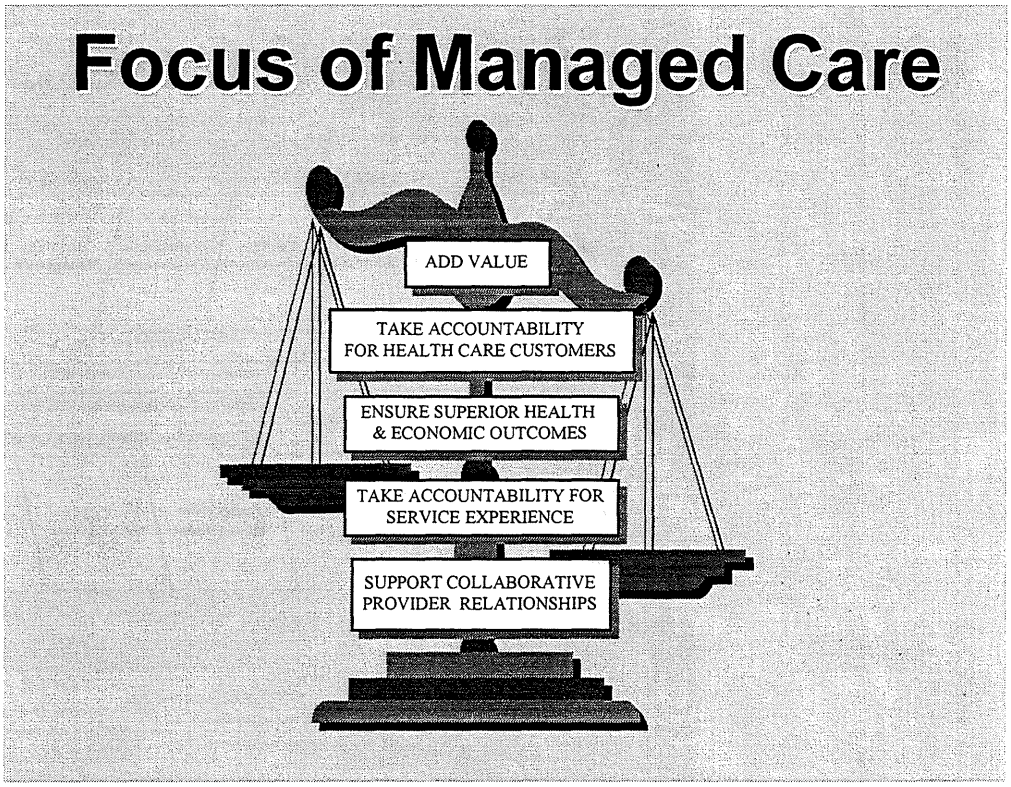


What is Managed Care?

Managed care is a variety of business initiatives that promote cost effective, quality health care for our customers. It helps contain the rising cost of traditional health care services by managing the actual delivery, utilization, location, and duration of medical services.

BCBSF sees managed care as the development and implementation of coordinated **care delivery** systems, monitored and evaluated through **care management** and delivery system capabilities which are effectively supported by **enabling strategies**.

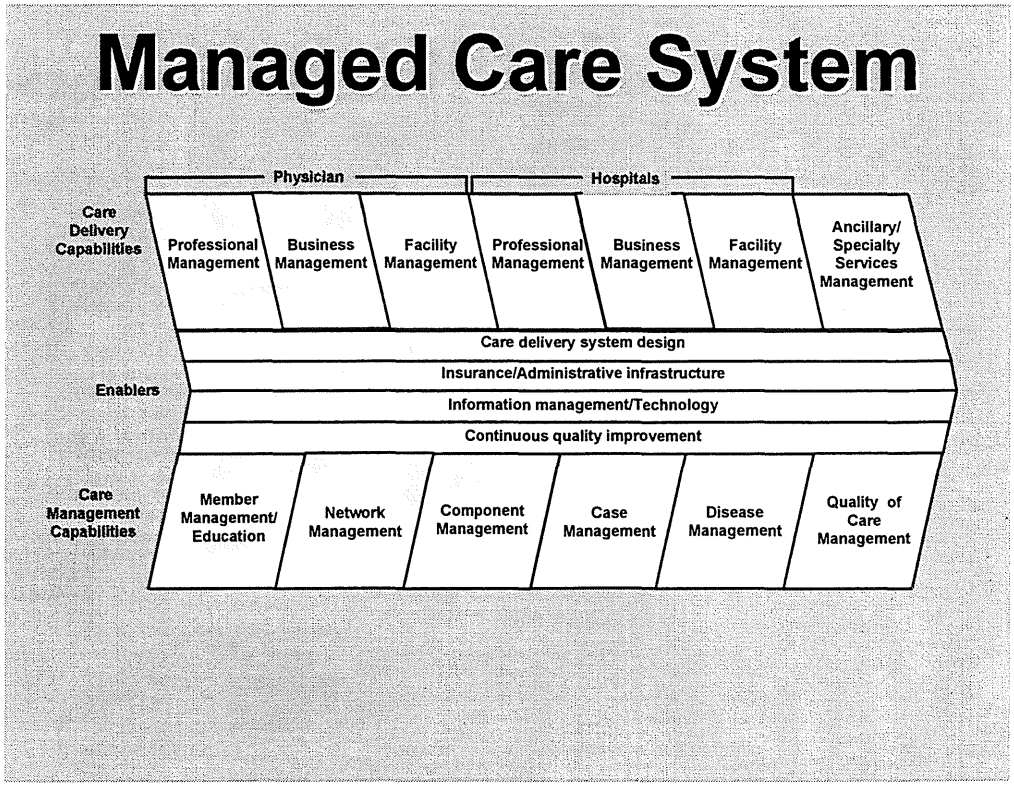
Case Management: One-on-One management of a specific med. service. (Pregnancy, chronic illness, etc.)
→ Minimize Risks for Case Manager.



BCBSF's Managed Care System

BCBSF's Manged Care System focuses on the ability to:

- add value
- take accountability for health care of customers
- ensure superior health and economic outcomes
- take accountability for entire service experiences
- support collaborative provider relationships



BCBSF's Managed Care System *(continued)*

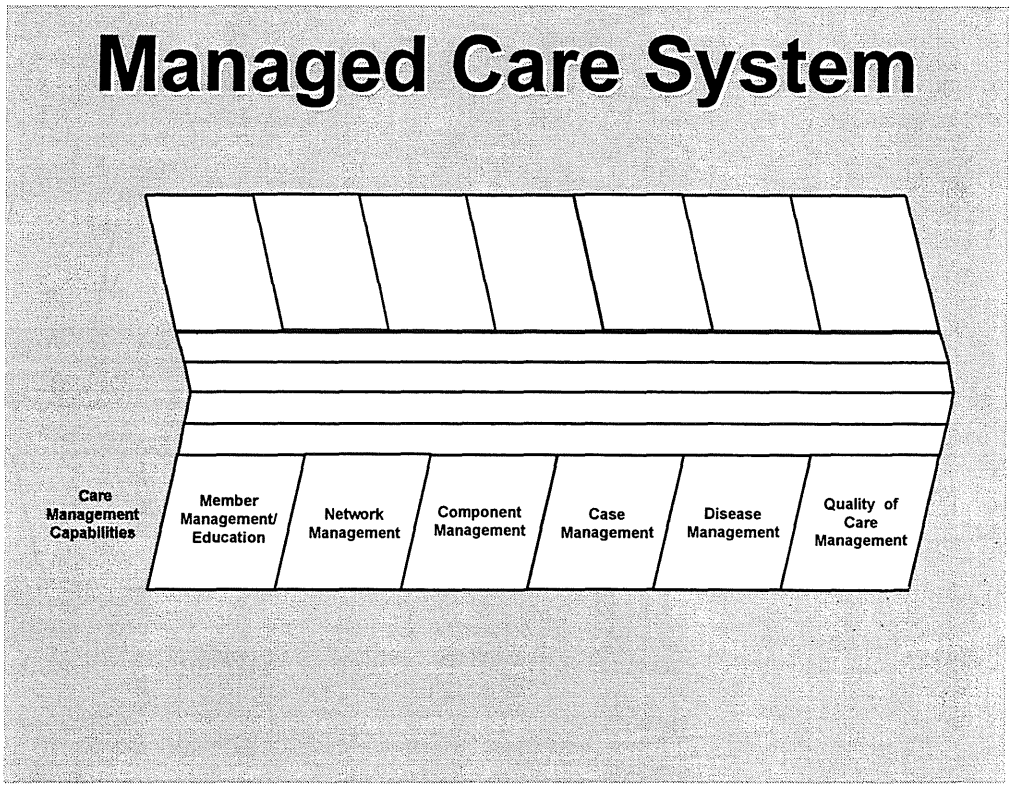
There are three fundamental components to BCBSF's Managed Care System:

- Care Management Capabilities
- Enablers
- Care Delivery Capabilities

Our Managed Care System gives us a greater capability for meeting specific customer needs. It also enables us to design individual delivery systems for and/or by market, integrating the services of acute care hospitals, skilled nursing facilities, laboratories, clinics and other ancillary services.

As the state's largest health care provider of health insurance and managed care products and services, customers expect our offerings to:

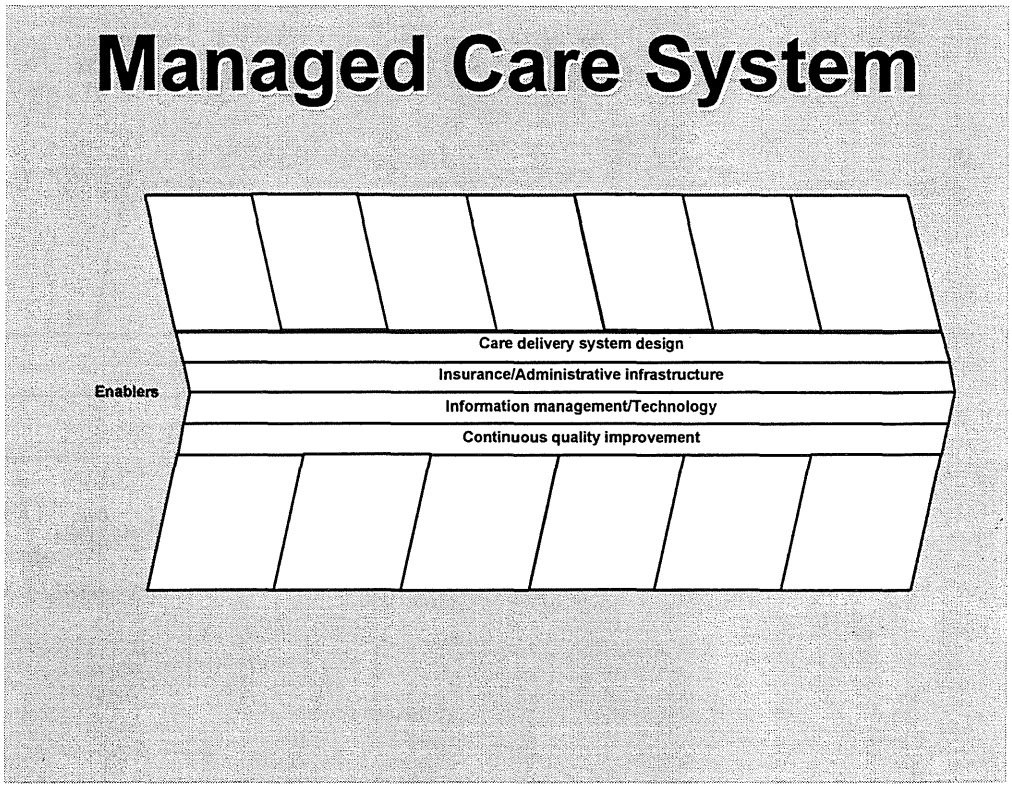
- meet their specific needs
- minimize rising health care costs
- ensure accessibility of quality care



BCBSF's Managed Care System *(continued)*

Care management capabilities include:

- **Member Management/Education** – benefit design, prevention programs, education and training, and informed decision making
- **Network Management** – selection, (re)credentialing and (re)certification; incentives; profiles, report cards and feedback; provider education
- **Component Management** – the authorization process, utilization review, formulary, and contract pricing
- **Case Management** – care tracking and appropriateness of care evaluations
- **Disease Management** – which includes specific disease management (e.g. diabetes)
- **Quality of Care Management** – practice guidelines, chart audits, member surveys, and outcomes management



BCBSF's Managed Care System *(continued)*

The second component are the ***enablers***. Think of enabling strategies as the "lubricant" or "oil" that allows the other two system elements or parts to operate effectively.

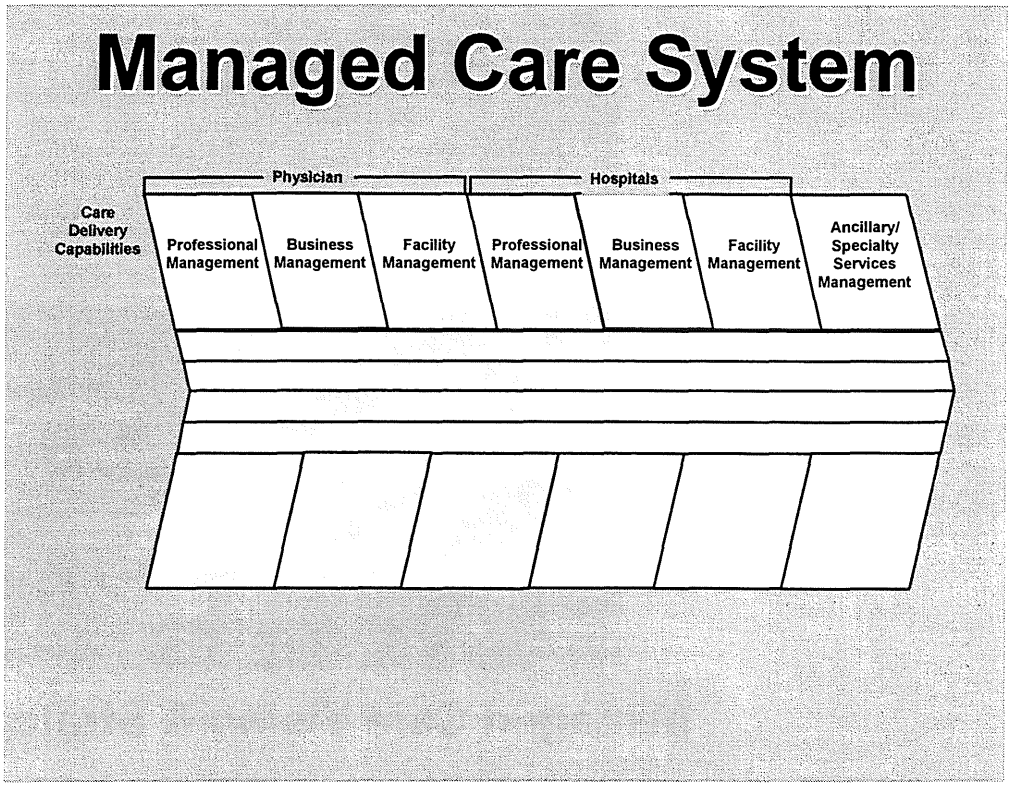
There are four enablers:

Care Delivery System Design – The ability to manage physician, hospital and member activities; to put the delivery system in place as we transition from an insurance company to a managed care company.

Insurance/Administrative Infrastructure – The cross training and development of new skills and a new organizational infrastructure in order to transition to managed care.

Information Management/Technology – The necessary technology, computer systems, data and information management capabilities to support managed care decision making.

Continuous Quality Improvement – Continual improvement of our business processes, products, and the way we do business.

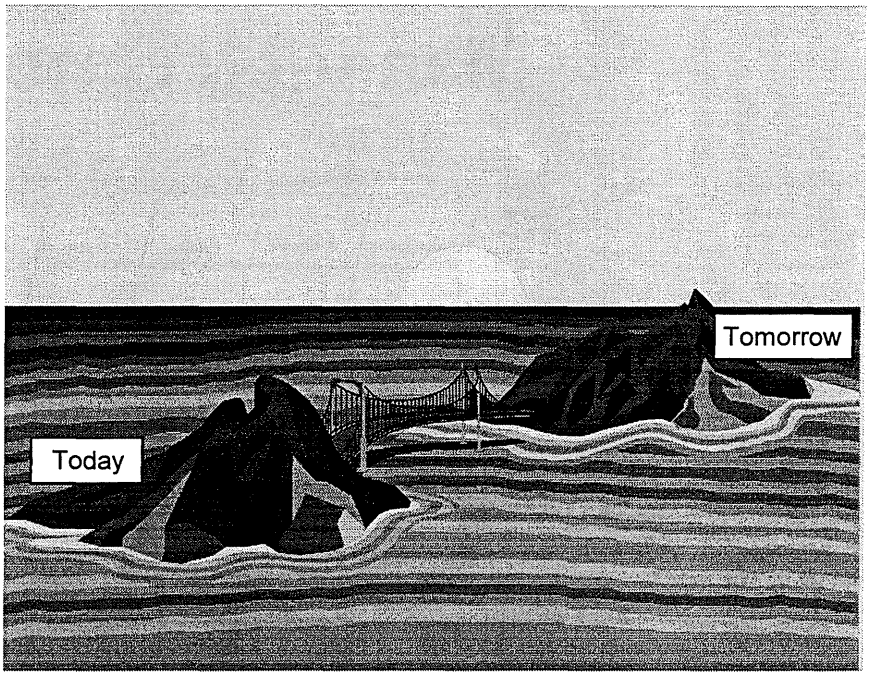


BCBSF's Managed Care System *(continued)*

Care delivery capabilities are the third component of the BCBSF managed care system. These capabilities involve management activities the company performs with three health care providers — physicians, hospitals, and ancillary providers. Management activities involve:

- **Professional Activities** – Collaborating and negotiating with providers delivering the care
- **Business Activities** – Assisting with office and hospital administrative work
- **Facility Management Services** – Making sure the right services can be and are delivered at the right place (i.e. outpatient or inpatient)

What is an ancillary provider?



Managed Care Vision & Strategies

BCBSF has a Managed Care Vision and strategies that bridge our care management capabilities from today into tomorrow.

By the year 2000, BCBSF will have the capabilities to add significant value to the processes by which our customers receive and providers deliver health care and related services by continuing to improve existing capabilities and concurrent development of new capabilities.

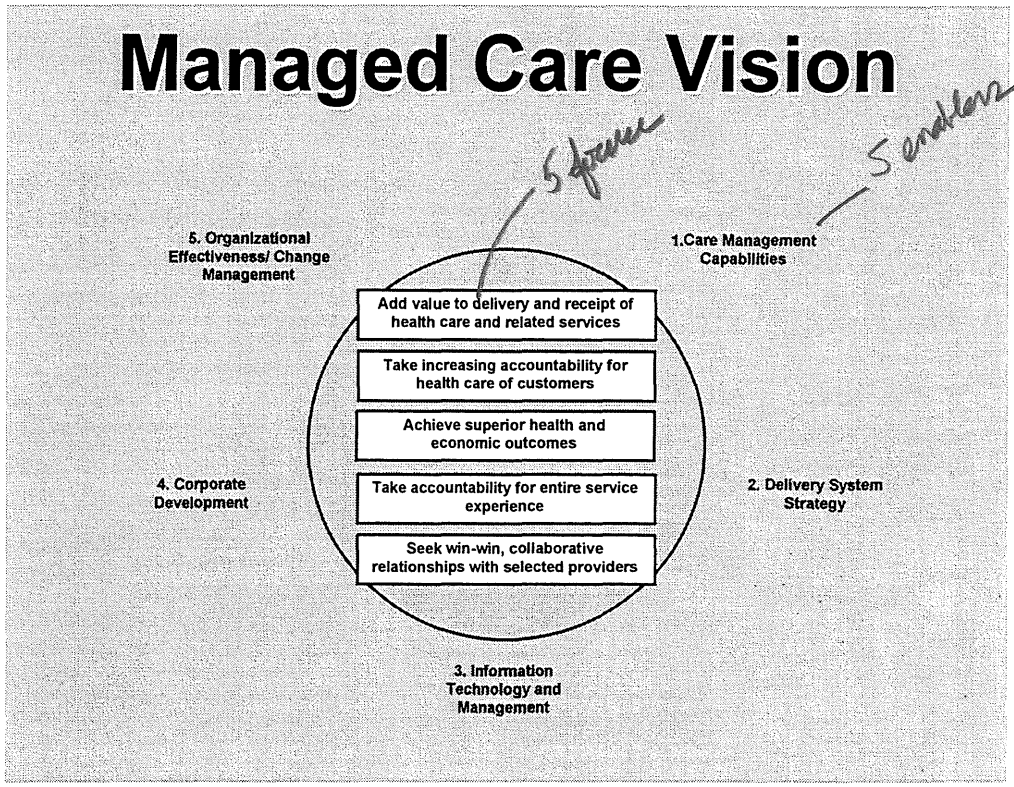
For our customers, BCBSF will add value by taking increasing accountability for the health care they receive.

- Continuous improvement in health outcomes
- Best possible corresponding economics
- Responsible for full service experience, including their interactions with the delivery system

With selected provider partners, we will seek win-win, collaborative relationships.

- Allow us both to achieve the best outcomes for out customers
- Add value in those relationships by providing superior medical leadership and by being easy to do business with

In executing this Vision, BCBSF will be recognized as a valued part of the health care system by our customers and providers. Aligned with other corporate strategies, this Vision will meet the needs of our customers by providing products and services with demonstrated superior quality, at competitive prices.



Managed Care Vision & Strategies *(continued)*

The BCBSF Managed Care Vision consists of five core objectives and five supporting strategies.

The five objectives include:

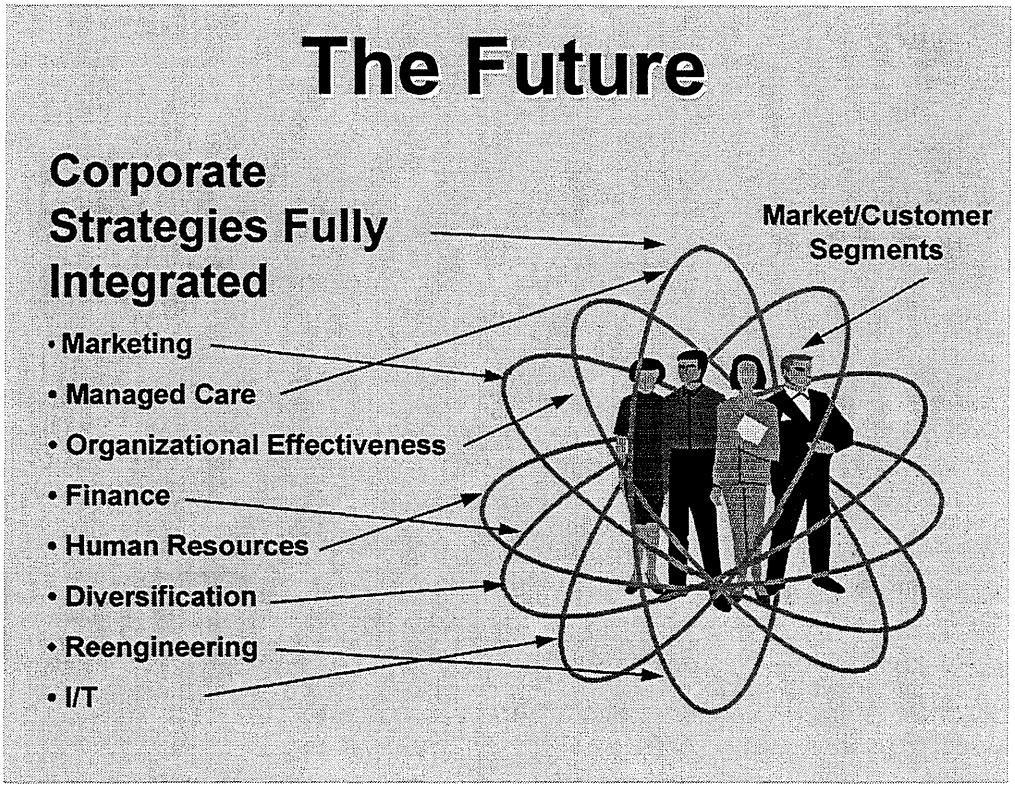
1. Add value to delivery and receipt of health care and related services.
2. Take increasing accountability for health care of customers.
3. Achieve superior health and economic outcomes.
4. Take accountability for entire service experience.
5. Seek win-win, collaborative relationships with selected providers.

The five supporting strategies are required to implement the Vision.

- Care Management Capabilities
- Delivery System Strategies and Capabilities
- Information Technology and Management
- Corporate Development and Diversification
- Organizational Effectiveness/Change Management

Notes

The Future



Compare BCBSF of today to the vision of BCBSF of tomorrow:

BCBSF Today	BCBSF Tomorrow
Health Insurance Orientation	Health Care Orientation
Transaction Management	Customer Service Management
"Bureaucratic"	"Responsive"
Discount focus: Win/lose	Selective Collaborative: Win/win
Manage components	Manage the system
Manage episodes/events of illness	Manage health/diseases
Quality assurances	Continuous quality improvement
Data for claims and operations	Data for health care management
Multiple contracts with providers	Umbrella contracts with partners
Regional initiatives	Corporate capabilities/consistency
Broad networks of providers	Influence with provider partners
Competition among providers	Competition among providers
Portfolio of products	Portfolio of products

Notes

Glossary

Glossary

Accountable Health Partnerships (AHP)	A group of insurers, doctors and hospitals that offer health care insurance to CHPA members.
Actuary	The mathematical and statistical experts who compute insurance risk and premium.
Administrative Costs	Expenses related to managing a business, such as the costs for personnel services (salaries, employee benefits), facilitites (buildings, office space, supplies), and equipment (computers, contracts).
Allied Health Products	Products that supplement basic coverage and provide benefits beyond those included in the basic or core health care product. Examples include vision care, dental care and prescription drugs.
Ancillary	Professionals who deliver services like nursing, dental, durable medical equipment and therapy.
Balance Billing	The practice of charging full fees in excess of allowed amounts, then billing the patient for that portion of the bill that the insurer does not cover.
Benefits	The level of payments provided for covered services under the terms of the policy.
Benefit Maximum	The maximum that an insurance or managed care company will pay per year, per illness, or per lifetime.
Business Outcome	An organization's consistent ability to do something of high value for its stakeholder, providing the company with a competitive advantage. A business outcome consists of a process, a stakeholder and a measureable target.
Capitation	A payment arrangement where a contractor receives a fixed rate per member.
Case For Change	A concise summary of where we are as a company and where we must be. It provides measures and descriptions of the future.
Case Management	A utilization management technique used with high cost cases that monitors treatment and recommend alternatives to long hospital stays where consistent with the doctor's treatment options.

Catastrophic	A serious or prolonged illness or injury, which could have an impact on a health policy.
Chronic	A medical condition lasting for a long period of time, or marked by frequent reoccurence.
Co-insurance	The employee responsibility in an arrangement with the insurer. Typically, in an 80/20 plan, the employee will pay 20 percent "out-of-pocket" (this is the co-insurance) of eligible expenses and the insurer will pay 80 percent.
Commercial Carriers	For-profit insurance companies that sell insurance to those "risk classes" from which a profit can be expected.
Community Health Purchasing Alliance (CHPA)	A state-chartered, non-profit private corporation that serves as a broker of affordable health plans.
Comprehensive Major Medical	A product that packages, in a single product, hospitalization, medical/surgical and major medical services. This is a wraparound product that marries major medical with traditional hospital.
Concurrent Review	Within 24 hours of a patient being admitted to a hospital, the hospital stay is monitored either by telephone, or by an on-site visit for appropriateness of care received and the continued stay.
Control Plan	A BCBS Plan that serves as headquarters for a national account group, and has primary responsibility for negotiating a National Account contract with a group, coordinating the administration of the group with Participating/ Servicing Plans, and administering the syndicate funds. Other responsibilities include establishing and administering the equalization funds and to reimburse the Participating/Servicing Plans.
Co-payment	A pre-determined dollar amount paid by the subscriber for outpatient services each time they receive care, paid at the time of treatment.
Cost	A production concept that measures the use of resources needed to make the product or service, and to deliver that product or service to the customer.
Cost Sharing	The employer passes on a percentage of the costs of health care to the employee. This is done in the form of deductibles, coinsurance, and benefit maximums.

Credentialing	Checking references and documentation of physicians.
Deductible	A dollar amount that a subscriber has to pay (within a 12 month benefit period) before health insurance begins to pay benefits.
Demographics	The characteristics of human populations and population segments, especially when used to identify consumer markets.
Diagnosis Related Group (DRG)	A payment arrangement that pays the hospital based on the diagnosis, regardless of how long or detailed treatment is.
Discharge Planning	A utilization technique that plans for the care of the patient after being discharged from the hospital.
Employees	Customer who are people who work for an employer (e.g. BCBSF employees).
Employers	Group customers who purchase products for their employees, also known as group administrators.
Fee-for-Service	A payment arrangement where the health care company pays the provider for each covered service after the service has been delivered.
Fee Schedule	A payment program where the managed care plan pays charges submitted by the provider or a maximum allowable payment (MAP) whichever is less. Some traditional products also use this program.
Forecast	An estimate of the future based on the past. In the health industry, it is the process of predicting future costs based on past data.
For-Profit Company	Companies that use their profits to pay dividends to their stockholders.
Gatekeeper	The primary care physician who provides or coordinates care of the insured and makes all referrals and authorizations for the care of that individual.
Government Programs	A part of BCBSF's business which is funded by the United States Government. This includes the Medicare Part A and Medicare Part B programs, administered by HCFA.
Group	A body of customers eligible for group insurance by virtue of some common attribute, such as employment by the same employer, or membership in a union or association.

Health Care Financing Administration (HCFA)	An agency with the federal Department of Health and Human Services that administers the Medicare programs and works with the states to administer Medicaid program.
Health Maintenance Organization (HMO)	A type of health care program offering benefits when services are provided and/or authorized by selected providers, usually with a primary care physician "gatekeeper".
Incurred But Not Reported (IBNR)	Claims that have been incurred (medical services have been provided), but not yet reported to the insurer. IBNR must be estimated and calculated in terms of claims dollars (costs) that will have to be paid as a result of services that have been rendered but not yet reported.
Indemnity	Benefits that provide reimbursement to the consumer for medical expenses, though usually not the entire bill.
Individuals	Customers who purchase health care products for themselves, because they are employed by groups who do not provide coverage, are unemployed, self-employed, or are in between jobs.
Industry	A group of firms that produce products or services that are close substitutes for each other and that compete directly for the same customers.
Inter Plan Teleprocessing (ITS)	A system that can route, send, receive and control institutional and *Services* professional claims submission and pricing information between Plans from different states. ITS serves as a delivery method for Control and Par accounts.
Lag Time	The period of time that occurs between when a claim is incurred (as the time of medical services) and when payment is made.
Managed Care	Programs that lower costs by channeling care to cost effective providers and settings, removing the fee-for-service temptation of doing more to collect more, and making preventive care and effective management of chronic illness a priority.
Margin	Reserve funds which consist of money set aside to cover future claims and operating expenses. Also called reserves.
Market	A place, real or imagined, where ideas, goods and services are tested, bought and sold.

Marketing	Focuses on the exchange of goods and services between a company and its customers. While selling focuses on the product, marketing focuses on the needs of the customer.
Market Segment Teams (MSTs)	BCBSF standing operating committees which develop strategies and business plans to meet the needs of numerous customer groups or market segments. Each team has responsibility for monitoring its products and services for satisfaction and profitability.
Maximum Allowable Payment (MAP)	The maximum that a contracted provider will be paid for delivered services.
Maximum Out-of-Pocket Expenses	A management feature that contains costs for the patient by limiting how much they must pay once the deductible has been met. When the limit has been reached, the insurer covers 100% of all medical expenses.
Medical Costs	Payments made to hospitals, doctors and other ancillary providers for the services they deliver to the customers or subscribers under contract with BCBSF.
Medical Surgical Benefit	Benefits that pay for doctors and other professionals.
Medicare	A federal insurance program which provides health care coverage for eligible persons aged 65 and older, and certain disabled individuals.
Member	Any individuals currently enrolled under a health contract. This could include the subscriber, spouse and children.
Mutual Insurance Company	A company owned by its policyholders and whose profits are either distributed as dividends to the policyholders or used for future investment or loss coverage.
Network	A group made up of doctors, hospitals, and other medical professionals who have signed an agreement with BCBSF to offer quality health care at negotiated rates.
Not-For-Profit Company	Companies that use their profits to either lower premium costs, or increase benefits without raising rates.
Outcomes Management (Measurement)	A program which measures patients' responses to treatment patterns in order to evaluate efficiency.

Participating Plan (PAR Plan)	A plan which assumes the performance of all functions associated with the National Account involvement including the assumption of an underwriting risk. A National Par Group is an account which is headquartered in another BCBS Plan's state and has the contract with the customer.
Payment for Hospital Services (PHS)	The PHS network compliments the PPO product called *Preferred Patient Care* by offering customers an additional "safety net" of savings for out-of-network hospital services. The customer pays a coinsurance level which is calculated from the discounted hospital charges.
Payment for Professional Services (PPS)	The PPS network coordinates with the PPC product line by offering subscribers additional benefits for out-of-network service.
Per Diem	A payment arrangement which pays hospitals a flat rate per impatient day. Most common to HMOs.
Point Of Service (POS)	A health care product that allows the customer to make a choice of level of coverage at the time the service is delivered. The greatest level of coverage occurs when the customer chooses a provider in the network; a lower level of coverage occurs when a provider outside the network is chosen.
PPC Care Manager	A point of service product that allows employees flexibility in choosing their own physicians and hospitals; benefits are paid at the highest level when services are rendered as authorized by the PCP; benefits are paid at a lower level when the member goes directly to any provider.
Preferred Provider Organization (PPO)	Type of health benefit program where the maximum level of benefits is received when the enrollee receives care from a physician or hospital within the "preferred provider" network.
Pre-Admittance Certification	A utilization management technique that requires a subscriber to receive authorization from a medical review agent before being admitted to a hospital.
Price	An exchange concept describing the actual payment a customer must make to obtain a product or service.
Product Differentiation	A strategy that distinguishes a company's product from that of its competitors by creating a perception of "superior value" in the eyes of the customer in terms of product quality, special features, or after-sale service.
Profit	The financial gain of a business after all operating expenses have been met.

Provider	Physicians, other health professionals, hospitals, skilled nursing facilities, or other entities that provide health care services.
Provider Profiling	A management technique centered around collecting data on cost, utilization and quality indicators for providers.
Reengineering	The fundamental rethinking and radical redisng of an entire business to achieve dramatic improvements in critical measures of performance such as cost, quality, service and speed.
Request For Proposal (RFP)	A formal request by an employer to an insurance or managed care company for information regarding claims, experience and proposed benefits design
Revenue	Money taken in by the company from the sale of its products or services.
Risk	The possibility of loss in the event of unforeseen circumstances.
Risk Class	A group of insured individuals who have something in common, such as a certain type of coverage, exposure to certain types of health hazards, etc.
Second Surgical Opinion (SSO)	A utilization management technique where an individual is encouraged to receive a second opinion for surgery.
Segmentation	Dividing a market based on size, geography, need or other variables or attributes.
Self-insure	A health care plan where the employer takes on the risk on paying for the health care of the employee, as opposed to an insurance company taking on the risk.
Subscriber	An individual in whose name an insurance contract or agreement is issued. Also known as the contract holder.
Supplemental Major Medical	A major medical product that introduces a deductible and other cost sharing features once basic hospital and medical benefits have been exhausted.
Third Party Administrators (TPA)	Companies that provide administrative services only and do not take on the medical risks of a traditional insurance company. BCBSF is the third party administrator for the Medicare Part A and Medicare Part B programs.

Traditional Health Insurance	Type of health benefit program where the health plan reimburses an individual who receives covered services from any provider of choice. This plan has no network restrictions for services rendered, no geographic limitations, and no utilization management programs.
Trend	The rate of increase or decrease over time.
Underwriting	The process of establishing the relationship between risk, and the cost of that risk, and determining the appropriate premium cost for acceptance of the risk.
Usual, Customary and Reasonable Allowances (UCR)	An attempt to control payment for each service. Statistical data is gathered, reflecting what doctors in a given area charge for specific services, what it costs doctors in the area to practice, and other relevant factors. A common charge is determined (the UCR) which is usually lower than what a specific doctor actually charges.
Utilization	The frequency and duration of use of medical services.

Notes

Contact Information

Blue Cross Blue Shield of Florida Contact List

For additional information about any of the topics discussed in this program, please call one of the departments listed in the table below.

Department	Location	Phone Number
Corporate Communications	HOC-9T	791-8191
Corporate Library & Information Center	FC2-3	363-5345
Employment/Employee Relations	HOC-3OH	791-6281
	FC1-1	**363-4341**
Government Programs:		
Administration	HOC-18T	791-8155
Beneficiary Education & Outreach	HOC-15T	791-8103
Center For Continuous Learning	HOC-5C	791-8311
Provider Education	HOC-6T	791-8757
Managed Care	CP5-3	363-5852
Marketing:		
Education & Development	FC2-3	363-5340
Research & Business Analysis	FC2-3	363-5635
Organization Development & Training	HOC-3OH	791-6376
PBO Training & Development	FC2-1	363-5325
Public Relations - General Information	HOC-9T	791-6183
Public Policy	HOC-17T	791-8382
Reengineering Hotline	CP1-1	791-8227

This is an abbreviated department list. If the department you need is not listed, please refer to the *BCBSF Corporate Telephone Directory*. For a paper copy, or information on accessing the online version, call Telecommunications at (904) 791-6089.